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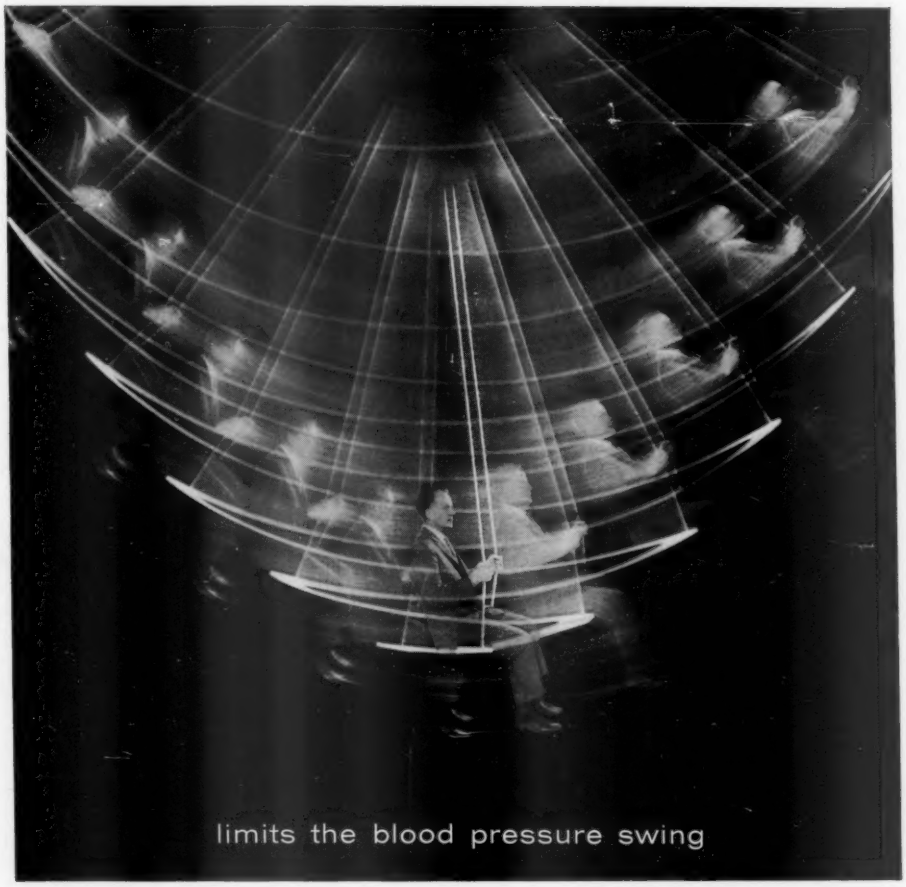

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Shadow or substance

Marcus J. Smith, M.D., Santa Fe, New Mexico

Apothegm

". . . often we must decide not only what the patient has got, but what the patient is suffering from" (Sir William H. Ogilvie).

Clinical data

A 60-year-old man was disturbed by a sensation of tightness in his throat, weakness, and diarrhea of one month's duration. There had been a concomitant 14-pound weight loss. His previous medical and surgical history concerned a hernia, hemorrhoids, a fistula in ano with an anal stricture, and pruritus ani. There was a moderately severe anemia with both the hematocrit and hemoglobin being decreased.

X-ray study

X-rays of the entire gastrointestinal tract were obtained, and the only unusual finding was in the esophagus, where a pulsion diverticulum (Fig. 1) was located. It measured 1.5 by 3 cm. and had a narrow neck. It presented posteriorly and to the right of the midline at the level of the first thoracic body.

Clinical discussion linked the diverticulum to the anemia by one of two mechanisms, either as the source of chronic bleeding, or in a manner similar to the esophageal web of the Plummer-Vinson Syndrome, which is associated with an iron deficiency anemia. Accordingly, the patient was admitted for the purpose of extirpating the diverticulum.

Clinical course

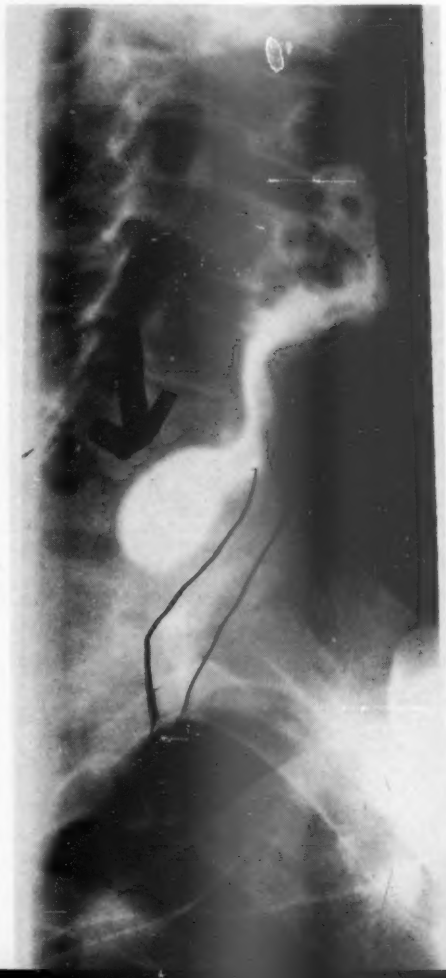
The surgeon, dissatisfied with the nebulous nature of the anemia, consulted with a clinical pathologist who pointed out that the sides of the patient's tongue were smooth, that his color was lemon yellow, that he did not have spoonshaped finger nails and that blood had not been convincingly demonstrated in his stools. An examination of bone marrow and peripheral blood now established that the anemia was megaloblastic, and in all features was compatible with a diagnosis of primary ("pernicious") anemia.

There was an excellent immediate and sustained response to vitamin B-12 therapy. Subsequently, there was an elective removal of the diverticulum, which showed a chronic inflammation. The patient was followed for two years, without recurrence of his difficulties.

Epicrisis

We must not become so enamoured of our positive x-ray findings that we attribute all of the patient's woes to them. Sometimes, these findings may obscure the significant clinical features.

Fig. 1



Just Give Me One Minute More!

SIXTY SECONDS is really not long enough to land a pan-size trout at the end of a four-ounce fly rod. Nor is it sufficient time to scythe the morning beard, whether it be with a double edge safety razor or your own favorite electric mowing machine. But when it involves the matter of *visiting* with your patient in *your* office on some subject far removed from his or her immediate medical problem, then Pardner, it's quite a spell!

Yes, I realize, Fellow-Scientist, that John Q. Patient came in to see you about his own particular physical worries and not for a chat about the weather forecast. Let's be a little frank right now, however, and admit the subject of the weather has been an opening wedge in the social functions of quite a few folks for several generations. There's always something more entertaining and enlightening that ultimately comes out of a get-together which starts off with, "Gee, but it sure has been a long, dry spell!"

By the process of simple arithmetic we might deduce that if a doctor saw 30 patients a day and talked to each of them just one minute more about something other than medicine. then he would have the finest half hour of investment in public relations that he could buy. The fact that a patient's personal physician was not only concerned with his recovery from a physical malady, but that he was also interested in John Q. as a person and a citizen raises the Follower of Hippocrates a couple of notches on the totem pole that members of the laity use to calibrate the ratings of professional people.

I know of a doctor whose Gal Friday runs a regular newspaper clipping service about his patients. Whether it's a picture of the semi-invalid after he has made a hole-in-one at the golf course or his tom-boy daughter winning the championship marble tournament of the fourth graders, said bit of newspaper propaganda gets cut out and clipped in the patient's office chart. Then the next time the poor, unsuspecting victim comes in for a review of his ulcer symptoms or a prostatic massage (heaven forbid), then all is forgiven with the flipping open of the chart and the casual display of the picture with the clincher question, "Say, Joe, did you use a three iron or a four wood for that hole-in-one on that long par three?" The only trouble with this particular guy is that you'll never get rid of him in the usual social visit of one-sixtieth of an hour that you promised yourself you'd devote to each and every patient.

But be kind and tolerant to him, Disciple of Aesculopius. You won't have an overabundance of patients in the hole-in-one category!

Family Doctor

Enforced Retirement and Mental Illness

COMPULSORY RETIREMENT at age 65 is being re-evaluated by many employers and large organizations. As life expectancy and good health during declining years has increased, experience and skill of older employees are now being carefully assessed. The A.M.A. has asked labor and industry to review their retirement systems with the thought of liberalizing retirement programs.

It is interesting that in Japan, which has always assigned dignity to the process of aging, incidence of mental illness decreases with age. Idleness, hopelessness, and the feeling of not being needed or wanted may be subtle etiologic agents in the high per cent of American hospital beds being occupied by patients with nervous and mental disorders. Paternalizing and coddling our "senior citizens" may be more of a disservice than suspected by proponents of benefits beyond the call of necessity.

Certainly the healthy and still productive people of 65 or more should not be shelved simply because they have reached that critical three score and five. There must now be

more realistic ways of evaluating productiveness. When they are perfected and applied, occupancy of hospital beds by older people will decrease.

Letters I Never Finished Reading Department

THE FOLLOWING ADVERTISING EPISTLE was one page long. We'll spare you all but the first paragraph and a half:

"Dear Dr. ————:

"You're probably as tired as I am of hearing about products that claim to save you time. These days, everything from paper clips to sailing ships is advertised as saving you time. If I could accumulate all the time I've been promised, I'd live to the age of Methuselah.

"All this talk of time puts me in a funny predicament. It happens that our company makes a product that truly saves you an appreciable amount of time. . . ."

As Yul Brynner might say, "et cetera, et cetera, et cetera." After years of receiving tons of mail and talking to battalions of detail men the average doctor learns to recognize a good sales pitch when he hears—or sees—one. No comment is needed on the quality of this one.

Have you ever noticed how easy it is to be windy if you're blabbing a letter into a machine and how terse and to the point your handwritten letters become? I'll bet that the above letter was dictated into an uncomplaining and uncritical machine.

Convulsions At C.B.S.

ON FEBRUARY 7, C.B.S. presented a program, "The Business of Health, Medicine, Money and Politics." Anticipating a program of objective unbiased reporting by this nationally prominent radio and television network, I watched first with avid interest, then amazement, at what was being shown and finally with disgust at what was an obvious propaganda program favoring the Social Security approach to medical problems of the aged and eventually everyone.

The following evening while reading the February 8 issue of Time magazine under the "Press" section the following headline caught my eye: "Convulsions at C.B.S." It is well worth reading. It states that the trouble in C.B.S.'s news department is something that no reorganization, however sweeping, is likely to cure. Most significant is the statement that the successor to the news Vice President is Blair Clark, who was graduated from Harvard in Jack Kennedy's class.

The A.M.A. Trustees' press release stated that "The real truth about the A.M.A.'s position on medical care lies on some C.B.S. cutting room floor." Could Mr. Kennedy's classmate, Blair Clark, the new General Manager and Vice President of the news division, have been responsible for this?

Let this be a warning to each and every one of us, A.M.A. member or not, President Kennedy is determined to push his Social Security health plan upon this nation; to lose the fight would be a terrific blow to an egotistical personality. We must be prepared to fight with every ounce of strength for the next eight years probably, four years at the least.

Wm. A. Day, M.D.

Not All News Is Black

IT'S NO TIME TO GET DISCOURAGED. True, there are wars in Laos and Cuba and some new African states, our town and gown disputes continue, and those who hate others' success pick the smallest flaw in one facet of medicine's jewels and magnify it into a Vesuvian crater. We still have Senator Kefauver, and the Washington socializers try harder than ever to turn America into a socialist-welfare state, starting with medicine.

But Blue Shield enrollment reaches a new high with every report, 47,000,000 for the country at the end of 1960. Another couple of legislatures have passed anti-cancer-quackery laws. A small county medical society vaccinates almost every child in all its county's schools against polio. A state society's House of Delegates goes all out—including a $50 assessment—for a real public education campaign. Hospitals improve, and the bed shortage is easing just a little. There are many other good signs. Not all the news is black.

Let's get busy and improve it even more!

The local cold injury*

Prevention and treatment

C. T. Yarington, Jr., M.D., Rochester, New York

This paper is particularly appropriate in a region where outdoor sports and industry are prevalent.

RECREATIONAL TRENDS OF MODERN SOCIETY are bringing many new and unique forms of injury before the eyes of the family physician. In this new era one is apt to forget or ignore some of the rather commonplace disorders which one associates with days gone by. Of all such injuries, none, perhaps, is taken so much for granted as the local cold injury. With the present knowledge of this condition at his disposal, today's physician is in a position to give counsel and treatment, not only to prevent the tragic sequelae of this type of injury, but to prevent its occurrence.

Based on the 55,331 cases of cold injury hospitalized in World War II and the 7,285 cases from the Korean War, many new concepts have been evolved as to the cause and prevention of cold injuries. These cases alone represent over three million days of hospital care during which all aspects of treatment were studied in detail. Based on this work and the more recent studies in preparation for space flight, much has been learned about the effect of cold on the human organism.

Three basic terms are used in describing cold injury. The terms are descriptive in nature and refer to the method of injury. They do not represent different degrees of injury or imply a different pathogenesis. The terms are:

Frostbite: A term denoting actual freezing, or near freezing of tissues. This can occur at temperatures of from +20° F. to −80° F. in from a few minutes to 16 hours, with a mean of 10 hours' exposure to a temperature of +11° F.

Trench foot: A result of exposure of from +20° F. to +50° F. for periods of from 2 hours to 14 days in a wet environment.

Immersion foot: A result of from 12 hours to 7 days of immersion in water of a temperature ranging from +25° F. to +60° F.

The resulting injuries are pathologically alike in quality, but differ in the total area involved and in the primary environmental situation causing the injury. In describing the degree of injury, one resorts to descriptive categorization according to degree of damage. The categories of extent of injury are as follows:

First degree: Numbness, swelling, and erythema without vesiculation. Slight desquamation may occur.

Second degree: Vesiculation of the outer layers of epithelium.

Third degree: The entire skin thickness is involved in vesiculation, with varied degrees of subcutaneous injury.

Fourth degree: Complete loss of the part involved.

The gross and microscopic findings represented by these lesions is best left to the standard texts on that subject. The basic vascular activity caused by heat loss at the site of injury is an initial vasoconstriction. A generalized vasoconstriction follows by reflex action, thus conserving the general body heat at the expense of the exposed part. On warming, the rapid dilatation of capillaries causes stasis and the formation of cellular sludge. Subcutaneous edema occurs in from two to six hours after warming and resolves within 24 to 36 hours. The edema fluid, released through the injured capillary

*From the Rochester General Hospital, Rochester, N. Y.

wall, is high in protein content and, therefore, presents a danger of subcutaneous organization and adhesion formation. These vascular phenomena are contributing rather than causative factors in the production of the cold injury, as actual tissue cooling and possible cellular death is the basic pathologic occurrence in the production of the local cold injury. The resulting tissue changes differ from thermal burns only in their lack of incineration.

The treatment of cold injuries should consist of immediate care and the necessary follow up of complications and residual pathology. The immediate care should include complete rest of the afflicted part. Any massage, cooling, or local tissue irritation should be avoided. The part should be brought to body temperature of 98.6° F. as rapidly as possible. This is best accomplished by immersion in water of temperature not exceeding 107° F. nor lower than 80° F. The use of radiant heat is not advocated for tissue warming. If over 36 hours have elapsed since the time of injury the rapidity of treatment will not influence the final result; hence, these lesions should be seen and treated as soon as possible after their onset. Antibiotics, tetanus antitoxin administration, bed rest, strict asepsis, and anesthesia when indicated should be as much a part of the treatment of a local cold injury as they are of the care of a severe burn. Dependent positioning of the injured part should be avoided, but too great a degree of elevation is likewise dangerous. Dressings should be employed in the same manner as with severe burns.

The late care of the cold injury is primarily control of infection, surgical debridement when necessary, amputation of necrotic tissue when a line of demarcation is clear, and physiotherapy. The use of vasodilating drugs, pressure dressings, sympathetic blocks, and anticoagulants has been unrewarding. The use of enzymatic agents for debridement is of questionable value.

Prevention of cold injuries is within the realm of every physician. Through the many vectors of communication at his disposal he can help eliminate this condition. Education of the public as to the need for adequate treatment and the avoidance of old fashioned, and often harmful, forms of first aid are a necessity.

The primary factors contributing to the production of cold injuries are: prolonged exposure, wet or inadequate covering, constrictive garments, lack of physical activity during exposure, poor nutrition, previous cold injury, and general debilitation. It is obvious that water, other good conductors, and wind blast will more rapidly cool a part than will exposure to the air alone.

Naturally some individuals are more sensitive to cold than others. The incidence of cold injury in "Southern" soldiers, in Korea, was 1.6 times that of those men from "Northern" states. The negro was six times as susceptible to cold injury as the white soldier. Those troops previously suffering cold injuries had a rate of injury twice that of their previously uninjured comrades, despite the supposed object lesson imparted by their injury. These facts bear out previously suspected relationships between cold injury rates and environmental origin.

Communication of this information and the obvious precautions suggested to the general public would go far in the prevention of cold injuries. Such simple acts as avoidance of long exposure, immediate changing of wet clothes, maintenance of physical activity while exposed to cold, and the use of the old adage, "once burned, twice shy," would be of great value as preventive measures. A healthy respect of these conditions, imparted by the physician to the general public, will contribute to the prevention of the loss of many man hours of work plus considerable amounts of tissue both in the community and in future military operations. These educational efforts, coupled by the use, by the physician. of all modern therapeutic methods at his disposal and the availability of adequate consultation should make the more serious results of local cold injury a thing of the past. ●

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Electromyography and its role in surgery*

Jerome W. Gersten, M.D., Denver

This is a clear exposition and elementary introduction to the theory and some applications of a relatively unfamiliar but clinically useful diagnostic instrument.

ELECTROMYOGRAPHY (EMG) HAS MATURED during the last decade so that it is no longer an electronic curiosity but a means whereby significant contributions have been made toward an understanding of basic neurophysiologic processes. A consequence of this expansion of fundamental knowledge has been the considerable aid given by electromyographic procedures in the diagnosis and management of surgical problems.

Before proceeding to these clinical considerations, it would be of value to consider briefly the basic framework on which our applications are based. Normal contraction of skeletal muscle is accompanied by changes in the electrical properties of the muscle membrane. These changes are propagated throughout the muscle fiber as the familiar action potential. Electrical changes of this type may easily be detected, amplified, and recorded. Equipment used in electromyography designed to do this consists of electrodes, a vacuum tube or transistor amplification system and a recording system (oscilloscope and camera or loud speaker and tape recorder). Depending upon the goal of the examination, surface (skin) or needle electrodes may be utilized.

The clinical technic of electromyography depends, as do all evaluations with a similar purpose, upon a recognition of the normal pattern of electrical activity in muscle, and how this may deviate in the diseased state. Only a few of the more pertinent facets of normal activity will be noted here. The normal muscle is completely silent at rest; there is no recorded electrical activity. If electrical activity due to failure to relax or due to stimulation of a small nerve fiber can be ruled out, then electrical activity at rest may be considered an index of a pathologic state.

Types of activity

Two significant types of resting electrical activity may be described—namely, the fibrillation and the fasciculation. The fibrillation potential is small in amplitude (approximately 100 microvolts in comparison with a few millivolts normally), extremely short in duration (1-2 milliseconds), and usually fires at a low frequency. It represents the spontaneous activity of the single muscle fiber which has lost its nerve supply and no longer contracts within the framework of the motor unit.

The fasciculation potential, too, may appear at rest. It may have an appearance similar to that of the normal motor unit action potential, or it may be highly polyphasic, depending upon the mechanism of production. There is a wide scatter in frequency of firing, from one every few seconds to 10 per second. The amplitude is much greater than that of the fibrillation potential, and closely approximates that of the normal potential. Fasciculations may be seen in anterior horn cell disease, in nerve compression and, often enough, in the normal

*Presented at New Mexico Medical Society (New Mexico Orthopedic Society) 78th Annual Meeting, May 13, 1960, in Albuquerque, N. M. The author is Professor and Head, Department Physical Medicine and Rehabilitation, University of Colorado School of Medicine.

individual. It is the existence of the latter, the benign fasciculation, which should make one extremely cautious in prognosticating serious disease in the presence of fasciculations alone. Suspicion may be excited by the fasciculation, and little more, and intensive search for more convincing evidence, in the form of fibrillations, may be undertaken, with repeated examinations, if necessary.

With this basis, and within this framework, we can now examine the role of electromyography in surgery more closely. Our uses of these procedures may be broadly categorized as falling within three areas—diagnosis, analysis of normal patterns, and re-education. In the first of these, needle electrodes are essential, while for the latter, two skin electrodes may often provide useful information.

Surgical diagnostic use of electromyography falls, in the main, into two main categories—compression and nerve injury. Among the relatively common causes of compression one may include herniation of an intervertebral disc, carpal tunnel syndrome and osteoarthritis of the cervical spine. I will restrict my comments to the first two of these.

Success with discs

The relatively high degree of successful EMG examinations in disc problems, over 80 per cent in my own experience, should lead one to consider this test even before consideration of myelography. There is no required hospitalization and no complications. The time required for a test may be viewed as a negative consideration. One may readily distinguish between local root pressure and a more general neuropathy. Fasciculations are seen in fewer than 50 per cent of patients with discs, but may occasionally be elicited by cough or Valsalva maneuver. The fibrillation potential provides the most secure evidence of muscle denervation. In disc, the denervation must proceed in terms of radicular patterns and should involve muscles innervated by posterior as well as anterior rami. Ordinarily a 4-5L disc leads to L5 signs, which means that fibrillations may be present in the tibialis anticus and lateral head of the gastrocnemius, but absent in the quadriceps and medial head of the gastrocnemius. Occasionally confusing is the more medially placed disc, which will produce root signs one segment lower than that anticipated. There are, of course, pitfalls other than this. Pressure on the posterior root primarily will result in the characteristic disc pain without any electrical signs of denervation. Furthermore, a period of two to three weeks may have to elapse before anterior root compression may present itself with appropriate fibrillation potentials. Despite this, the relative simplicity of the test should lead one to make use of it often, if not routinely, in instances of suspected disc.

Carpal tunnel syndrome

Detection of compression of the median nerve at the wrist may be considerably enhanced and facilitated by appropriate EMG testing. Ordinarily one need not wait for denervation, and hence skin electrodes, rather than needle electrodes, are used, placed over the abductor pollicis brevis. The median nerve is then stimulated at the elbow (medial to the brachial artery, at the level of the internal condyle of the humerus) and at the wrist (at the level of the ulnar styloid, and just lateral to the palmaris longus tendon and medial to the flexor carpi radialis tendon) and the time to the appearance of a potential in the muscle is measured from photographic records. Some of the observations noted on such stimulation, which differ from the normal, are repetitive firing with a single shock, and increase in asynchrony of the action potential, with an increase in duration and polyphasic quality of this potential. These are not sufficient in themselves, however, to do more than point the finger of suspicion to a compression in the carpal tunnel. More quantitative and characteristic information is needed, and may be derived from measurement of the time lapse from stimulus at elbow and wrist to appearance of a potential in the muscle. Normally such a delay is six to seven milliseconds on stimulation at the elbow and two to three milliseconds on wrist stimulation. From these data, and from a knowledge of the distance from the elbow to the wrist, conduction velocity may be calculated. This velocity, normally 50-55 meters per second, is unaltered in carpal tunnel syndrome. The essential

change noted with such compression at the wrist is a marked and significant increase in wrist to hand conduction time.

One of the most significant contributions which may be made in the management of the patient with apparent nerve injury is the determination of the nature of this injury. When a patient presents himself two or three weeks after injury, with paresis or paralysis, the existence of an organic interruption of nerve continuity may be demonstrated by the appearance of fibrillations. If, after such a time lapse, fibrillations are absent, it may be presumed that the paresis is based on stretch with consequent conduction block, in which instance the prognosis for recovery is good, and surgical intervention need not be considered. One can also, in instances of organic nerve injury, watch the process of recovery through the use of EMG, and detect at the earliest possible time a delay in recovery which may necessitate surgery.

Normal patterns

The analysis of normal patterns of movement, through the use of skin or needle electrodes and a multichannel oscillograph, may contribute meaningfully to many surgical problems. The analysis of normal gait patterns has been pertinent from at least two standpoints. A better understanding of the problems of the amputee together with a more rational manufacture of prostheses, has been one of the results of a more detailed understanding of muscle inter-relations during normal and abnormal walking.

A second significant area requiring an understanding of kinesiology during ambulation is that of the muscle transfer. By and large, transfer of muscles which are active during the same phase as the muscle being substituted for is more successful than nonphasic transfers. As far as the leg is concerned, the stance phase muscles would include the gastrosoleus, peroneus longus and brevis, tibialis posterior, flexor hallucis longus, flexor digitorum longus, abductor hallucis and flexor digitorum brevis. Swing phase muscles include the tibialis anterior, extensor hallucis longus, and extensor digitorum longus. Neither of these groups is all-inclusive. In the nonphasic transfer, although voluntary control may be readily achieved, there is a remarkable tendency to lose the desired activity during automatic processes, such as walking. The clearest picture of phase of muscle activity, in all its detail, may be achieved with EMG technics.

Use in re-education

We come finally to the utilization of electromyography for re-education purposes. The basic problem in all the instances which may fall into this category is that a muscle, normally innervated from the organic standpoint, cannot readily be made to contract volitionally. The mechanisms whereby this may occur are only imperfectly understood, and need not delay us. The purpose of the electromyographic procedure is to detect the very few active motor units, which often are not sufficient to produce gross movement, and amplify these so that they may become visual or aural stimuli to the patient—by projection onto a screen or loud speaker. It is then hoped and anticipated that these may then facilitate voluntary movement. One may visualize diverse situations in which the above circumstances may be operative, and in which this technic may then be used with value.

In tendon transfer, in the upper extremity especially, it occasionally occurs that with utilization of all the more standard technics, the transferred muscle will not contract, or will do so only to a limited extent. In these instances, re-education with EMG may well be used to advantage.

One also notes, from time to time, muscle paresis of the neuropractic type, without nerve injury, or paresis following apparent recovery after organic injury. The author has had occasion to note this several times in the facial musculature. In these instances, fibrillations were absent, and a few, isolated fairly normal potentials, were found. In many of these patients, a much more substantial contraction could eventually be elicited. These contractions were seldom equal to the normal, either in strength or in quality, but they served the patient far more satisfactorily.

A final example, though by no means completing the list, of a valuable area for re-education, is the relatively silent muscle one notes after casting. Not infrequently, after

two to three months of immobilization, and especially in the older person, there is undue difficulty in eliciting a contraction in that immobilized muscle. This has become a rather familiar picture in the quadriceps. It would seem at the moment, and this has to be verified by a more rigorous experimental approach, that electromyographic re-education technics may result in a more rapid return of function in these muscles.

Summary

It has not been my goal here to present an intensive treatise in the realm of electromyography, but only to indicate. through a few examples, how the intelligent use of this technic may provide considerable aid in practice in one area of medicine. I should like to terminate with one note of caution, an extremely important one. Although I have often, for the sake of convenience, referred to this as a technic, it cannot be considered such in the same sense that urinalysis is a technic, for electromyography resembles more closely auscultation of the heart. Taken within this framework, it is obvious that electromyography should be performed by a clinician who is fully aware of all the clinical implications in any given case, and not by a technician. •

Cancer quackery*

Joseph L. Kovarik, M.D., Denver

You will enjoy this well-written commentary upon the "second oldest profession." We have an obligation to help protect our people against the perennial quack.

Public Beware!

WARNING AGAINST THE HOXSEY CANCER TREATMENT

Sufferers from cancer, their families, physicians, and all concerned with the care of cancer patients are hereby advised and warned that the Hoxsey treatment for internal cancer has been found worthless by two Federal courts.

The Hoxsey treatment costs $400, plus $60 in additional fees—expenditures which will yield nothing of value in the cure of cancer. It consists essentially of simple drugs which are worthless for treating cancer.

The Food and Drug Administration conducted a thorough investigation of the Hoxsey treatment and the cases which were claimed to be cured. Not a single verified cure of internal cancer by this treatment has been found.

Those afflicted with cancer are warned not to be misled by the false promise that the Hoxsey cancer treatment will cure or alleviate their condition. Cancer can be cured only through surgery or radiation. Death from cancer is inevitable when cancer patients fail to obtain proper medical treatment because of the lure of a painless cure "without the use of surgery, x-ray, or radium" as claimed by Hoxsey.

Anyone planning to try this treatment should get the facts about it.

For further information write to
U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Food and Drug Administration
Washington 25, D. C.

MEDICAL QUACKERY has been referred to as the "second oldest profession," dating back to 1500 B.C. Today it is estimated that there are over 4,000 cancer quacks in the United States and that the American public spends approximately $10,000,000 a year for their ministrations. A name currently synonymous with cancer quackery is Hoxsey. Harry M. Hoxsey started with an eighth grade education and his "cancer cure," secured a naturopath's license in 1936, and opened his clinic in Dallas. In spite of numerous legal entanglements, including many arrests and the closing of his Portage, Pa., clinic following a U. S. District Court injunction, his Dallas establishment still flourishes as the Taylor

*Presented at Nevada Annual Meeting, September 7-10, 1960.

Clinic. In 1956 this clinic treated 8,000 patients and grossed $1,500,000! In 1946 the Food and Drug Administration issued 46,000 posters which were displayed on post office bulletin boards throughout the country alongside posters of other public enemies. This represented the first large-scale warning against a worthless remedy by the U. S. government.

Hoxsey "tonics"

The Hoxsey treatment, which may be purchased for approximately $400.00, consists of remedies for both internal and external cancer. The external treatment features arsenic escharotics with an alternate choice of the same arsenical mixed with K-Y jelly for subcutaneous injection. For the internal cancer Hoxsey has a Red Tonic and a Black Tonic. The Red Tonic consists of elixir of lactated pepsin with potassium iodide. The more popular Black Tonic includes cascara sagrada, potassium iodide, extracts of Buckthorn, red clover blossom, prickly ash, alfalfa, sugar and water.

In addition to the usual advertising media, Hoxsey has authored a book entitled "You Don't Have to Die." He has also widely published a report of 10 doctors, all M.D.'s, who spent two days at his clinic in 1954. They issued the following statement: "We as a committee feel that the Hoxsey treatment is superior to such conventional methods of treatment as x-ray, radium and surgery. We are willing to assist this clinic in any way possible in bringing this treatment to the American public. We are willing to use it in our offices, in our practice on our own patients, when at our discretion it is deemed necessary." Needless to say, not one of these doctors is recognized as an authority on cancer. Also needless to say, not one of Hoxsey's claims of cure has been substantiated*

While Hoxsey is the king pin of cancer quackery, he is by no means the only one. A Duke University group investigated 62 different cancer cures in their area. Some of these were honest but uneducated backwoodsmen who sincerely believed in their remedies. The Duke group also referred to a 24-page publication received from an "institution in Colorado" which presented testimonials of former patients successfully treated with a new internal, external, and dietary cancer cure. The Nichols Sanatorium in Savannah, Mo., is well known for its use of arsenical paste, which results in disfigurement in the case of benign lesions, and inadequate or ineffective therapy for malignancies.

The current public interest in radioactivity proved a boon for a cancer quack in Lone Rock, Wis. He advertised a radioactive tunnel where cancer victims could crowd in, for a fee, to reap the benefits of a short exposure. Investigation with a Geiger counter revealed the tunnel emitted radiation equal to that of a radium watch dial (or as one reporter put it, "as radioactive as the fall-out from a firefly"). Other current quack cancer cures range from potions and lotions to electric massage and flashing colored lights. They have one thing in common—they are worthless.

Acquisition and display of a medical degree does not always insure that a man will not resort to quackery. William F. Koch was graduated from Detroit College of Medicine of Wayne University in 1918, after having been on the faculty of this school and the University of Michigan in the departments of anatomy and physiology. In 1919 he discovered "Glyoxylide," which was subsequently reported by government chemists to be indistinguishable from distilled water. Legal action finally forced his departure to Rio de Janeiro in 1948. His income was estimated at $100,000 a year, and "Glyoxylide" is still being used in many areas of the country.

Several years ago, Dr. John E. Gregory, a graduate of the California College of Medical Evangelists, discovered a new antibiotic in his backyard which he modestly named "Gregomycin." This antibiotic supposedly kills the virus that causes cancer, and pictures of this virus taken with an electron microscope were offered as proof. In spite of repudiation of these claims after investigation, Dr. Gregory treated approximately 300 patients a day and his annual gross income reached $400,000.

Dr. Andrew C. Ivy's original report on Krebiozen, like so many quack advertisements, consisted of various doctors' narrative

*"Complete and final discontinuation" of the Hoxsey cancer treatment by federal court order has been announced by the Food and Drug Administration. (A.M.A. News—October 3, 1960.)

reports on their patients' clinical response. These narrative reports were individually notarized! Krebiozen is a white powder prepared from serum of horses injected with material from "lumpy jaw" — presumably actinomycosis. It was named by Drs. Stevan and Marko Durovic, and the Greek translation is "Creator of Biological Force." This "biological force" is not only considered to be worthless in the treatment of cancer, but also fostered vindictive developments which included the dismissal of a University President and the expulsion of Dr. Ivy from the Chicago Medical Society—a sad development in an otherwise outstanding medical career.

Some non-quacks dangerous

Incompetent M.D.'s are not quacks but are almost as dangerous. A timid or untrained surgeon, a radiotherapist who uses inadequate doses of x-ray, or a physician who administers homeopathic doses of hormones or other chemotherapeutic agents is usually afraid to expose his ignorance. Medical meetings on cancer, and establishment of hospital tumor boards and conferences, are a great help in this regard.

Support of cancer quackery comes from many sources. There are radical publications such as a newspaper called "The Defender" from Wichita, Kan., and "Man's Magazine" which support Hoxsey and his ilk. More surprising are such figures as U. S. Senator Toby of New Hampshire who praised the so-called "Bacteriophage" cancer treatment of Dr. Robert E. Lincoln in a speech on the floor of the U. S. Senate, later published in the Congressional Record. State Senator John Haluska of Pennsylvania has long been an ardent and outspoken supporter of Hoxsey. U. S. Senator William Langer of North Dakota used his franking privilege in 1948 to circulate an excerpt from the Congressional Record in which he supported Koch's "Glyoxylide."

Cancer quacks emphasize that trauma, in the form of surgery and x-ray, can cause cancer. They point to current medical investigation of cancerocidal drugs, perfusion technics and hormones as evidence that the medical profession admits that surgery and x-ray are inadequate or ineffective. Quacks have perverted the term chemotherapy and apply it to their nefarious concoctions. With this background of fear and confusion, it is no wonder that quacks have influenced people in all walks of life, including some of our prominent citizens. Consulting charlatans has been compared with the physician's liability to consult wildcat stock brokers. Some of the most responsible M.D.'s will always be in the hands of financial fakers, and some of the most responsible business men in the hands of medical fakers.

What can we in the medical profession do about this problem? We must individually and collectively inform the public, as well as our private patients, of the criminal danger of the cancer quack, notably that curable cancer patients will needlessly die and that incurable cases are denied more effective palliation, not to mention the patient's economic exhaustion. We can do this by reporting any cases of cancer quackery to our local State Medical Society where appropriate action can be initiated. Aid may then be sought through local law enforcement agencies, the Bureau of Investigation of the A.M.A., the federal and state Food and Drug Administration, the Committee on Cancer Diagnosis and Treatment of the National Research Council, and the Committee on Quackery of the American Cancer Society.

News media are helping

We must educate and police our own membership and then urge other healing groups, such as osteopaths, to do likewise. Most metropolitan newspapers, in addition to national periodicals like Time and Newsweek, render a true public service in helping to inform and educate the public. We must continue to cooperate with them and with medical columnists and science writers. And probably, most important of all, we must not abandon the terminal cancer patients, so they will have no recourse to consult quacks.

The philosophy of most cancer charlatans may be summed up by quoting a slogan which Harry Hoxsey keeps on his desk—"The world is made up of two kinds of people, dem dat takes and dem dat gets took." We must impress on our patients and the public that these so-called "cancer cures" are for the birds and that quacks are for ducks. •

A pathologist looks at his myocardial infarction*

Karl T. Neubuerger, M.D., Denver

This paper was originally intended to be an informal speech; however, after it had been read, several colleagues encouraged the author to prepare and modify it for publication. As the audience consisted mainly of physicians interested and active in sports, special emphasis was laid on problems of the elderly coronarian regarding outdoor activities, and general adjustment to the changed situation.

IT IS A TRUISM that coronary heart disease is frequent in physicians. In 1955, 3,088 physicians died in the United States. Forty-eight per cent of them had heart disease, and in 31 per cent it was explicitly stated that coronary occlusion, coronary thrombosis or myocardial infarction were the cause of death (Ritter and Haas)[1]. However, Master, on the ground of recent studies, expresses doubt that coronary thrombosis is a "doctor's disease."[2] In the fascinating book, "When Doctors Are Patients,"[3] the reader will find brilliant descriptions of the way doctors reacted to, and put up with, their diseases, and coronary heart disease, of course, has been given ample consideration. I should like to give first a brief history of my own case, not from the hospital chart, which I have never seen, but from my own experience.

Up to the beginning of the seventh decade of life, I paid little attention to my heart, although my father's death from a coronary attack at age 49 could have made me heart-conscious. At age 43, I noticed palpitations after drinking strong coffee. Several years later there were occasional mild palpitations after exertion or excitement, sometimes with minimal anginal pain, but these disturbances were too insignificant to worry about. At age 60 I took a responsible position as hospital pathologist, in addition to a considerable teaching load at the medical school. At age 62, in 1952, I planned a trip to Rome in order to participate in the First International Congress of Neuropathology. I had been asked to read a comprehensive paper on neuropathology of vasal diseases on this occasion. The heart attack occurred a few days before the scheduled departure.

Etiologic factors

Now, what are potential agents in the formation of an infarct? They are enumerated in scores of textbooks and papers, and so I will name only some of the essential ones. Mechanical factors are mainly coronary thrombosis and coronary sclerosis with gradually increasing stenosis, intramural hemorrhage, or lack of adaptability due to calcification and medial atrophy. Other, sometimes pertinent factors are, for instance, heart hypertrophy of a degree that the coronary system can't supply satisfactorily the enlarged heart; variations in the vasal pattern, for

*Read at a meeting of the Rocky Mountain Traumatic Surgical Society, Aspen, Colorado, January, 1960. From Department of Pathology, General Rose Memorial Hospital.

instance, underdevelopment of one of the arterial branches; postoperative, traumatic, or postanginal shock; influences of weather; hypoxemia (carbon monoxide, anemia); increased blood coagulability; overtaxation of the heart (work, physical exertion, psychical factors); electrical instability, and coronary spasm.

Just a few words as to spasms and related vasomotor disturbances. While we believe that spasms do occur, and may be pathogenetically significant, they are certainly rare in older people with severe sclerosis; here the muscular coat of the media is atrophic, fibrosed or calcified, and certainly not capable of spastic contraction. Failure of the diseased vessel to react to vasomotor stimuli and consequent sluggish circulation of blood are of greater significance. The decisive factor in the genesis of myocardial infarction lies always in insufficient blood supply, from whatever causes, to a certain portion of the myocardium at a given time. Once the infarct has formed and healed, gradual improvement of the myocardial performance is possible due to formation of collaterals, cautious training of the heart, and therapeutic improvement of blood supply. Moreover, the heart of the aging, less active and more sedentary coronarian, will be less demanding, and will be able to get along on a curtailed blood supply.

In my personal case, if I may immodestly come back to that, several factors played a role, in addition to organic coronary disease. I will mention only one of them. There was overwork, with a 70 to 75-hour week, during several months with great heat, which I never managed to get accustomed to; in addition, I covered several miles on my bike every morning, did some swimming in the evening, and took strenuous mountain hikes every second or third weekend.

The attack

Now I will briefly describe how the actual attack came about. During the first part of August, 1952, I had a particularly heavy load of autopsies and surgical specimens. While the English version of my paper was completed, the French and Italian translations were yet to be taken care of, and I felt that the fear of not getting done with these tasks in the few remaining days was the straw that broke the camel's back.

On the day of the attack I didn't feel too peppy in the morning and was not in the mood to do any exercise. After breakfast I drove to the hospital and performed two autopsies without undue effort or exertion. Around noon I experienced some of the sensations which I have described before, but this wasn't bad, and I was not alarmed. In the early afternoon when I cut surgical specimens, I didn't get on satisfactorily, for I began to feel restless and somewhat dyspneic. I had a sensation of tightness over chest and belly, accentuated over the heart and accompanied by parasthesias in the left arm, mainly a feeling of cold over a circumscribed area of the volar surface of the lower arm. There was but little pain in the arm. I had to interrupt my work repeatedly, but I didn't feel much relief. I looked in the mirror, and I knew what was up. Oppression in the chest, dyspnea and weakness were ever increasing. Things became rather muddled in my mind from then on, about 4 p.m. I called my family, and they urged me to stay at the hospital, the sensible thing to do, but I wanted to get home, to stretch out and lie flat. Sensations at home were the same, only more severe, with some cold sweat. Pain was not nearly as intense as described in the books, but there was the feeling of an only 50-50 survival chance, with surprisingly little fear of a possibly imminent death. While lying there wretchedly, I admired my wife for her calm and self-control. Our friend, Dr. Abe Ravin, came presently. I felt I was in good hands. I guess I smiled imperceptibly when he answered my question whether or not this was a coronary by saying, "Not necessarily." An ambulance arrived shortly. When the attendants carried me out, I felt rather ridiculous, and I was mad at the neighborhood children, who curiously stood around. Once at the hospital, I was terribly fatigued, but I felt rather secure under oxygen, and somehow relieved that the strain of the trip to Europe was removed. There were many events, I am sure, which I wasn't aware of. I do recall an attack of dyspnea around midnight. The next day I slept most of the time. The morning after, I very foolishly got up and shaved, with subsequent fibrillation. From then on, things went rather smoothly.

Sometimes, however, I had a peculiar

feeling of guilt—as a man prone to exaggerated self-analysis, I told myself: You have known for decades what is good or bad for your heart; if you had shunned some things, and done others, you might have avoided the attack; you acted wrongly and, to some extent, you must blame yourself for your disease.

I rested for about six weeks; during the last of these weeks I learned to walk again for about half an hour. Less than two months after the attack, I started doing autopsies. This gave me a little self-confidence. Slightly over three months after the attack, I hiked up Flagstaff mountain from Boulder, a three-hour round trip, with a climb of about 1,200 feet, and thereafter I felt as proud as if I had climbed Mt. Everest.

Changed ability and goals

Now, how does one put up with the changed situation? Over the following years, attacks of dyspnea, extra-systoles, tachycardia, and minimal anginal pain, probably due to acute coronary insufficiency, occurred on various occasions, especially on mountain trips, which I couldn't manage to stay away from. The mental anguish of such experiences is difficult to describe. In a typical attack there is no fear of certain catastrophe; there is rather the depressing feeling that, while you are still sure-footed as before and really could enjoy the climb, your heart, vessels and lungs fail to cooperate, and thus destroy the fun. You sense your time as a mountaineer is up. You look toward the slopes of Red Peak in the Colorado Gore Range, for instance, which you climbed in good shape a few years ago. The slopes now seem unbelievably high, steep, and inaccessible, and you feel hopeless and sad. You can do one of two things: Give up completely, or try to train again, very gradually and cautiously. Well, I chose the second alternative. And now I will give a few pieces of perhaps somewhat trivial and subjective advice to my future co-coronarians, and to those who have had their first attack. I am thinking especially of the ones past middle age.

Don't set your goal too high, in mountain climbing or skiing, if you care to continue these sports. Turn back when you don't feel up to it, even if you lose face and your ego is hurt. Dress warmly, especially on ski trips, for your circulation isn't as good as it used to be. Never, never start a trip on a full stomach. Eat sparingly while on the trip. Go very slowly. Don't attempt to reach too high altitudes. If you just have to go high up, then have a long rest, half an hour or so, at 11,500 or 12,000 feet. Prophylactically, before starting take a tablet of quinaglute or pronestyl, and a coronary vasodilator like peritrate; this certainly does not do any harm, and is perhaps mainly of psychological value; maybe a placebo would do the same trick. In order to build up collaterals and to keep trim, try to walk at least a mile or two every day, or ride your bike four or five miles or more, and do moderate swimming or tennis playing and the like.

And, outside of sports (I know how difficult it is to heed these suggestions): Avoid rush, strong emotions, arguments, worrying; just as in sports, don't set your goal too high. Try to regulate your heart action, to wit: In a stress situation, when palpitations and extra-systoles are threatening, pull yourself together, and consider how unimportant and insignificant things are, viewed sub specie of eternity. It is amazing that will power can, to some extent, influence your heart action.

Avoid complete fatigue and exhaustion, both mental and physical. It may be the straw that breaks the camel's back. Don't forget that a threatening storm may cause heart troubles in weather-sensitive persons; virus infections may do the same. Avoid strong coffee and cigarets; you know that the safest way to prevent lung cancer is to smoke so many cigarets that you die from coronary heart disease in early age, before lung cancer has had an opportunity to develop. Alcohol, taken in moderation, is probably harmless and causes welcome relaxation.

It will help, at least psychologically, to keep your blood cholesterol down by regulating the diet, and/or by taking MER29 or thyroid. But these problems, as well as the question of using anticoagulants, are still moot, and certainly are beyond my capacity; therefore I will not discuss them here. The great German poet, Goethe, has said, if I may translate freely: "Shun what isn't yours. Don't brook what upsets your peace of mind." Maybe this is a good maxim for precoronarians. And be prepared for the possibility of

sudden, fatal heart failure. Think of the beautiful Latin saying (likewise freely translated):

In between hope and sorrow, and in between panic and anger,
Mind that any day may have dawned to be ultimate for you;
Gratefully enjoy the hour you didn't dare hope for. •

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Lipoma of the cecum

Report of one case

Hugh S. Collett, M.D., Elko, Nevada

A concise review of a rare enteric tumor.

LIPOMAS OF THE COLON occur infrequently but more often than other benign tumors. Because of their size or location they can simulate the presence of cancer. This case report describes a lipoma of the cecum which produced symptoms of partial intestinal obstruction. Evidence is presented which suggests that this tumor developed during a six-month period.

CASE REPORT

Mrs. M. V., aged 52, underwent complete hysterectomy, bilateral salpingo-oophorectomy, and appendectomy on May 3, 1960. The large and small intestine were explored at the time and no tumors were noted. Three months later she complained of constipation and subsequently the development of persistent cramping abdominal pain. Barium enema examination discovered a 5 cm. filling defect at the ileocecal valve (Fig. 1). On November 10, 1960, the patient was taken to surgery for exploration. The mass felt to be the size of an orange, was freely movable, and was located within the cecum adjacent to the ileocecal valve. Because of the probability that the lesion was malignant, the cecum was not opened. A right hemicolectomy was done with end to end anastamosis of the ileum and transverse colon. When the surgical specimen was opened, a 7 x 6 cm. purplish mass with superficial ulceration was seen in the cecum. Microscopically the mass proved to be adult type fat tissue in the submucosa. The patient's postoperative course was uneventful.

History and incidence

Bauer described the first intestinal lipoma in 1757. A recent review of the literature by D'Javid[1] lists 278 cases of colon lipoma.

Lipomas have been reported in patients aged 10 months to 87 years with the average age being 55 years; 75 per cent occur in females.

Pathology

Microscopically lipomas are composed of adult fat cells; 90 per cent occur in the submucosa and 10 per cent in the subserosa. Occasionally subserosal lipomas become very large but they rarely produce symptoms and are not considered in this article. The submucous type project into the bowel lumen and may be sessile, polypoid, or

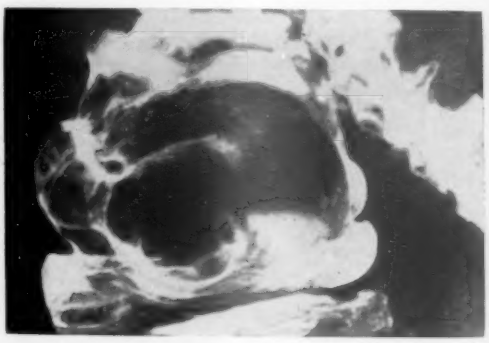

Fig. 1. Large, smooth, well defined filling defect in cecum.

pedunculated. They are usually smooth, ovoid, or spheroid in shape, and covered by intact mucosa. The size is variable from millimeters to several centimeters. The commonest colonic site is the ileocecal area where these tumors may grow to large size before producing symptoms. Lipomas in the sigmoid and rectal areas are less frequent but are more often symptomatic. The hard, dry stool of the distal colon often causes erosion and bleeding of these tumors.

Signs and symptoms

Many lipomas of the colon produce no symptoms and are found incidentally at surgery or necropsy. Lipomas in the left colon tend to cause constipation or diarrhea and they bleed more commonly than right sided lesions because of the more abrasive nature of the distal fecal stream. Pain of vague or cramping sort may occur. Large tumors cause frank obstruction. Intussusception occurs in some 19 per cent and these cases present with typical sudden severe pain associated with shock. Ulceration occurs in 16 per cent and obstruction in 7 per cent.

Diagnosis

Low lying lipomas are identified visually by sigmoidoscopic or proctoscopic observation. They have a faint yellow color and are soft and easily compressed by the scope. Elsewhere in the colon one must rely upon barium enema examination. Roentgenographically lipomas usually show smooth well-defined margins, and the adjacent bowel retains its flexibility and pattern. They are usually spheroid or ovoid and appear to be centrally located in the bowel lumen when seen en face or to arise from one side of the bowel when seen in profile. With air contrast radiography lipomas may sometimes be identified by the fact that air density and fat density are very nearly the same[2].

Differential diagnosis

Other tumors as carcinoids, adenomatous polyps, fibromas, and leiomyomas should be distinguished, but the principal differentiation is from cancer which has a predilection for the same age group as lipoma. Unless cancer can be excluded with assurance, the patient should be treated as if the lesion were malignant.

Treatment

Small rectal or sigmoid lipomas can be removed through the sigmoidoscope or proctoscope. Polypoid, roentgenologically benign lesions may be enucleated or resected locally. If gross examination cannot exclude a malignant tumor, radical cancer surgery should be performed. The relative rarity of lipoma, the difficulty in distinguishing from cancer in the unopened bowel, the hazard of cancer spill from the bowel in case of erroneous diagnosis, and the low mortality in the properly prepared patient recommends this approach.

Summary

A case of colon lipoma is presented with evidence indicating that it developed during a six-month period. The general entity is reviewed. •

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MATERNAL MORTALITY

The following cases have been reviewed by the Colorado Maternal Mortality Committee* and selected for publication because of their educational value. Submission of similar cases is invited from other committees in the Rocky Mountain Region.

Case 7†

This patient was a 38-year-old grav. 2 para 1, whose EDC was Aug. 13, 1959. Past history revealed that the patient had suffered chronic and recurrent pyelitis for several years and had been hospitalized several times for treatment of this condition. Her previous pregnancy had been complicated by mild pre-eclampsia. Her prenatal course during the present pregnancy was complicated by persistent edema of the extremities and backache. In addition, on several occasions, she had "black-out" spells, sometimes persisting for as long as one hour. A physician who saw her at home during one of these attacks thought that the patient had an epileptic seizure. At no time during her prenatal course was her B.P. elevated. Weight gain was 30 pounds. The urine intermittently showed 1-plus albumin. Because of edema and albuminuria, the patient was admitted to the hospital on Aug. 7 for observation and treatment. She had no elevation of B.P. The edema improved on bed rest. The baby was in breech presentation, and there was polyhydramnios. The cervix was thought to be favorable so I.V. pitocin was started by continuous drip. No progress was made after 24 hours and the I.V. was stopped. External version was accomplished successfully with the head remaining in the pelvis.

I.V. pitocin was begun again the following morning and labor progressed normally. The patient was taken to the delivery room at 7 cm. dilation approximately six hours after the onset of labor. Her blood pressure had been normal throughout. At this time, she was given 1 c.c. of Nisentil followed in about 10 minutes by caudal anesthesia using 25 c.c. of 2 per cent pontocaine. No spinal fluid was aspirated and an initial dose of 2 c.c. of solution resulted in no untoward reaction. Approximately 10 minutes after caudal anesthesia was started the patient suddenly went into convulsions and collapse. Both heart beat and respirations ceased. The chest was opened and cardiac massage begun. Positive pressure oxygen maintained respiration. An I.V. vasopressin and bood transfusion was started. The baby was delivered by cesarean and seemed in fair condition. Cardiac massage was continued and the heart beat was finally restored by the use of the cardiac stimulator. The chest was closed and the patient was placed in a Monahan respirator. The patient remained comatose with widely dilated pupils. Spontaneous respiration was never established. The heart beat became weaker and ceased approximately eight hours after the initial cardiac arrest. There was no autopsy.

Comment

The circumstances of this death from cardiac arrest suggest an accident due to idiosyncrasy to pontocaine or the entrance of pontocaine solution into the circulatory system via the venous plexus of the caudal canal. It was the opinion of the committee that this death was not preventable.

Case 8

This 39-year-old white female was admitted to the hospital on July 8, 1959, with the presenting symptoms of lower abdominal cramps and vaginal bleeding. LMP was May 7 and the onset of symptoms was on the day prior to admission. Examination on admission revealed marked pain and tenderness in the lower abdomen and tissue present in the dilated cervical canal. Temperature was 39° C. An immediate D&C was done and it was noted that the patient was passing only minimal amounts of dark-brown urine and she was transferred to the Medical Service for possible dialysis. At this time BP was 100/70, pulse 78, temperature 39° C. The skin and lips were cyanotic and the neck veins were full. Heart and lungs were normal. The abdomen was tender and bowel sounds were absent. Laboratory findings initially were: Hematocrit 35, WBC 19,900, Sodium 135, Potassium 4.35, Co_2-16.9, Chlorides 99.5, BUN 29, Plasma hemoglobin 348 mgs. per cent. The patient rapidly became hypotensive, B.P. 70/50, and blood transfusions were not successful in restoring the B.P. Intravenous Levophed was started.

On the following day because of clinical signs of peritonitis, a peritoneal tap was done and gram positive cocci were demonstrated in the smear of peritoneal fluid. Penicillin and Chloromycetin were then administered intravenously. On this therapy, the symptoms of peritonitis subsided within 24 hours, and the temperature dropped to 38° C. However, despite hypertonic glucose, sodium exchange resins and I.V. bicarbonate, the oliguria persisted. Serial electrocardiograms did not show any evidence of hyperkalemia. The clinical course was that of continued deterioration. Vasopressor agents were required continuously to maintain the blood pressure. On the second hospital day, the patient developed gallop rhythm and on the fourth day pulmonary edema. Despite attempts at I.V. digitalization the patient expired at 10:45 p.m. on July 12, 1959.

continued on page 68

*Committee Members: E. N. Akers, M.D.; Gerard W. delJunco, M.D.; George M. Horner, M.D.; Paul F. McCallin, M.D.; Leo J. Nolan, M.D.; James R. Patterson, M.D.; L. W. Roessing, M.D., and Ben C. Williams, M.D., Chairman.

†Previous cases reported in May, September and November, 1960.

to Prevent Overweight Through Better Eating Habits

Recipes and Menus with Satiety and Appetite Appeal in Mind

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color cook book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to *best* weights by sex, age, size and extent of activity.

Many diets fail because they are crash programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way is not a crash program. It offers calorie controlled menus with appetite appeal, variety and satiety in mind. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Not a reducing manual. It should be explained that "The Cook Book of Glorious Eating for Weight Watchers" is a guide to the *prevention of obesity*. Its publication marks the first time that a food manufacturer like Wesson has taken so important a step to help combat this serious public health problem.

Copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" is being offered to the general public. If you would like a copy for yourself, together with forms to enable patients to obtain their own copies, please fill in coupon below.

Note: *Please do not confuse this booklet with the Cholesterol Depressant Diet Book, published by Wesson as an aid to physicians and* for professional distribution only. *The concept of the Cholesterol Depressant Diet Book stems from Wesson's value in cholesterol depressant diets. Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, poly-unsaturated Wesson is unsurpassed by any readily available brand.*

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Please send me my copy of "The Cook Book of Glorious Eating for Weight Watchers", plus two dozen order blanks for distribution to my patients.

_____ M.D.

ADDRESS

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THE WASHINGTON SCENE

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

The seriousness of the national problem of mental illness was emphasized on three fronts recently in the nation's capital.

First, the Joint Commission on Mental Illness and Health reported on a comprehensive five-year study of the over-all problem. Second, another special government advisory committee recommended smaller community-sized mental institutions after a two-year study of facilities for care of the mentally ill. Third, a Senate subcommittee held hearings on the constitutional rights of mental patients.

The Joint Commission recommended sweeping reforms in the treatment of mental illness as well as expanded and improved facilities. It said some gains had been made in the past 10 years but that the need for adequate facilities for humane, healing treatment of the mentally ill is still largely unmet.

More than half of the patients in state mental hospitals do not receive any treatment, largely because of inadequate facilities, the commission said.

The commission recommended that government spending at all levels—federal, state and local—for public mental patient services be stepped-up in the next decade from the present $1 billion a year to $3 billion a year.

Another recommendation was that there be a fully-staffed, full-time mental health clinic for each 50,000 of population.

The commission, which was created in 1955 by a special act of Congress, had 45 members representing every national association and nongovernment agency concerned with mental health. The American Psychiatric Association and the American Medical Association had the leadership in setting up the commission.

The government advisory committee, composed of 12 state Hill-Burton and mental health authorities, recommended that states concentrate on smaller community or regional facilities "offering a wide spectrum of services."

Dr. Luther L. Terry, Surgeon General of the Public Health Service, urged state governors to use the advisory committee's recommendations as guidelines for improving mental health facilities.

The Senate Constitutional Rights Subcommittee heard from Dr. Winfred Overholser that there is no foundation to charges that many Americans are

"railroaded" into mental hospitals. Dr. Overholser is superintendent of St. Elizabeth's Hospital, large federal mental institution in Washington, D. C.

Dr. Lauren H. Smith, vice chairman of the A.M:A.'s Council on Mental Health, told the subcommittee that the A.M.A.'s future program in the field will include emphasis on more use of psychiatry in geriatrics, pediatrics and medical education, both at student and postgraduate levels.

Other activities planned for the A.M.A. program include closer coordination of activities of the A.M.A. council and corresponding committees of state medical societies.

The Food and Drug Administration, after the government filed suit against two drug firms for counterfeiting, reported that an extensive investigation showed that there is still relatively little counterfeiting of drugs.

Of 2,700 samples of drugs collected from 900 drugstores in the first three months of this year, only nine were found to be counterfeit.

FDA Commissioner George P. Larrick said he expected the problem of counterfeit drugs to continue because of the lure of easy profits. But he said results of the investigation supported the FDA view that "the facts to date do not warrant disturbing sick people about the quality of medications that they have been taking."

In the counterfeiting suit, General Pharmacal Co., Hoboken, N. J., and Lowell Packing Co., Long Island, N. Y., and eight officials of the two firms were charged with manufacturing counterfeit tranquilizers, diuretics, weight reducers and other drugs and selling them to drugstores in six states. The Justice Department charged that the companies put markings on pills making them appear like other trademarked brands.

FDA ordered manufacturers, effective May 27, to supply samples of new drugs for testing by the government agency prior to clearance for sale.

In the past, the FDA has relied largely on scientific data supplied by the manufacturers themselves in clearing a new drug as being safe for sale. The FDA tested the drugs only on a limited

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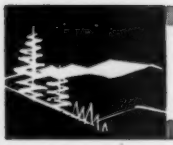

COLORADO

Annual Session dates changed

At its recent Midwinter Clinical Session the Colorado State Medical Society's House of Delegates approved a change in meeting dates for the 1961 Annual Session. Previously scheduled for late September, the dates have now officially been set as October 1-4, at the Shirley Savoy Hotel in Denver. This was done so that the meeting will overlap the A.M.A. Congress on Occupational Health, which is scheduled to meet at the Brown Palace Hotel October 3-4.

By combining the meetings the Society feels that this will help cut down on the multiplicity of meetings scheduled for Denver this fall, since the A.M.A. Clinical Meeting also will be meeting in Denver, the last week in November. Also it is believed that both meetings will benefit, with the Congress bringing to our Rocky Mountain area many fine talks which should be of interest in our growing industrial times.

Make plans now to attend the combined sessions this fall, October 1-4, in Denver.

Your Medicolegal responsibilities

It has come to the attention of the Chairman of the Medicolegal Committee that many malpractice claims and suits are not being reported to the Executive Office. The following is quoted from the "Rules and Regulations Concerning Malpractice Claims and Suits" for the information of the membership of the Colorado State Medical Society:

"It shall be the duty of any member of the Society who is sued, or threatened with suit, for alleged malpractice to fill out at once and mail to the Executive Secretary of the Society a report of the case, on blanks provided for this purpose. Blanks are obtainable from the Executive Secretary of the Society.

"Should any member of the Society learn of a suit or threatened suit against any member of the medical profession, it shall be his duty forthwith to notify the Executive Secretary of the State Society, or the Chairman of the Medicolegal Committee."

Obituaries

Former pathologist passes away

Paul C. Carson, M.D., died recently in Denver at the age of 62. Dr. Carson was born in Louisville, Kentucky, on July 7, 1898, and had his premedical training at the University of Indiana. He graduated from the School of Medicine at the University of Indiana in 1923 and came to Colorado the next year. He was licensed in Colorado in 1924 and served as pathologist at Presbyterian Hospital from 1925 to 1946, after which he continued to practice medicine in Aurora.

Dr. Carson was a member of the Denver Medical Society as well as the Adams and Arapahoe County Societies. He was a member of the Colorado State Medical Society, the American College of Physicians and Surgeons and Phi Beta Phi Medical fraternity. In addition he was an honorary member of the Denver Medical Club as well as a member of the American Legion and the Masonic bodies, the Englewood Blue Lodge, Colorado Consistory and El Jebel Shrine.

Surviving are his wife and a son, as well as his brother, a psychiatrist at the Colorado State Hospital at Pueblo.

Denver anesthetist passes away

Dr. Phillip Cloye Allen died February 26, 1961, after a short illness. Phillip C. Allen was born in Salida, Colorado, on December 8, 1901, and was graduated from the Colorado University School of Medicine in 1927. He was chief resident physician at St. Luke's Hospital in 1927, and was a member of the Denver Medical Society, the Colorado State Medical Society and the American Medical Association. His specialty was anesthesiology.

Surviving him are his wife, two daughters and two sons.

Rocky Ford veteran dies of injuries

Dr. Byron B. Blotz, veteran physician and surgeon at Rocky Ford, died March 17th from injuries sustained in a fall at his home in February.

Dr. Blotz was one of the earliest physicians in Colorado to make a serious study of medical economics, socialized medicine and allied subjects, and made more than one trip to Europe to study socialized medicine systems there during the 1920's and early 1930's.

He had practiced in Rocky Ford since 1906, and established the Physicians Hospital there in 1917. Dr. Blotz was a graduate of the University of Colorado Medical School and a member of the Otero County and Colorado State Medical Societies.

Dr. Blotz is survived by his widow, two daughters and one brother, all of Rocky Ford.

Industrial Doctor in Pueblo dies

Dr. Arthur W. Evans died in Pueblo on February 27, 1961, en route to a hospital after a heart attack at home. Arthur W. Evans was born October 14, 1912, at Wichita, Kansas. He received his A.B.

degree in 1934 from the University of Kansas at Lawrence, Kansas, and in 1938 he received his M.D. degree from the same school. He served his internship at St. Vincent's Hospital at Portland, Oregon, from 1938 to 1939. His residencies were at the Kansas State Tuberculosis Sanatorium at Norton, Kansas, and at the University of Kansas Hospitals in Kansas City. During World War II, Dr. Evans was a Captain attached to the 147th Field Hospital Unit. For many years he was Medical Director at Fitzsimons Hospital.

He was interested in industrial health work and was examining physician at the Pueblo plant of the Colorado Fuel and Iron Corporation for 15 years.

Dr. Evans was a member of Pueblo County Medical Society, the Colorado State Medical Society, the American Medical Association, the American College of Chest Surgeons and the American Industrial Hygiene Association.

Surviving the doctor are his wife and two daughters.

SOCIETY PROCEEDINGS

Abstract of Minutes*
House of Delegates of the Colorado State Medical Society

Twenty-sixth Midwinter Clinical Session
February 28, March 1, 1961
Hilton Hotel, Denver

FIRST MEETING
Tuesday, February 28, 1961

Vice Speaker Fredrick H. Good, Denver, called the House to order at 10:15 a.m., in the Terrace Room; and Speaker Heman R. Bull, Grand Junction, and Vice Speaker Good alternated in presiding throughout the session.

The Rev. Alexander Lukens, Rector of St. Barnabas Episcopal Church, pronounced the invocation.

President Cyrus W. Anderson led the delegates in the Pledge of Allegiance to the Flag.

Dr. Harper Kerr, Chairman, Committee on Constitution, By-Laws and Credentials, presented the committee's printed report and verbally amended it by recommending the seating of Dr. Matthew Gibson, delegate, and Dr. Fred Branan, alternate, from Adams County-Aurora Medical Society; Dr. Roy F. Dent, Jr., and Dr. John J. Sampson as additional delegate and alternate from the El Paso Medical Society; and Dr. E. G. Merritt as delegate from the San Juan Basin Medical Society.

Vice Speaker Good designated Drs. Covode and Blandford as Sergeants-at-Arms.

Eighty-four (before adjournment increased to 90) accredited delegates answered the roll call.

Speaker Bull addressed the House on procedural matters and announced that he and Vice Speaker Good had directed Harvey Sethman, Executive Secretary of the Society for 31 years, to deliver a verbal supplement to his printed report on problems of public relations and patient relations in the physician's own practice, to speak with utmost frankness, and to address the House not as an employed administrative officer but as a public relations man who knows what is good and what is bad about medical public relations, and to make any recommendations he believes are indicated.

Dr. Bull paid a special compliment to the Council on Governmental Relations and its chairman, Dr. Bradford Murphey, who have met weekly for several months.

Minutes of the last Annual Session were approved as published in the December, 1960, issue of the Rocky Mountain Medical Journal.

Reports of the Board of Trustees, Judicial Council, Grievance Committee, A.M.A. Delegation, and Executive Secretary were presented as printed.

Mr. Sethman then delivered his special prepared supplemental report†, as instructed by the Speaker.

The report of the Council on Medical Service was received, and supplemented by Chairman John H. Amesse, M.D., of Denver, who presented the following report for the Blue Shield Advisory Committee:

The Advisory Committee approved a few requests for changes in Blue Shield's Fee Schedule which involved either clarification of Plan benefit or the addition of procedures not currently included in the schedule. Two items were referred to the Executive Committee for further study before making a final recommendation.

The regular monthly meeting of Blue Shield's Adjudication Committee was held in conjunction with the Advisory Committee meeting. Material concerning the function of the Adjudication Committee and the types of cases which require special consideration was distributed, and actual cases included on the Adjudication Committee's February agenda were discussed and acted upon. The Advisory Committee found this particularly interesting, and expressed the hope that the Plan would in some way distribute the material to the profession at large.

Dr. Bradford Murphey presented the printed Report of Council on Governmental Relations, together with a mimeographed supplement that had been delivered to all delegates.

Dr. Murphey added that the Council had just met with Governor McNichols, Dr. Cleere, Dr. Galvin, Dr. Ebaugh, Dr. Zarit, Dr. Gaskill and Dr.

continued on page 57

*Condensed from the shorthand record of Bertram Naster, Certified Shorthand Reporter. Reports referred to herein as printed or mimeographed were distributed to all members of the House of Delegates at the 26th Annual Midwinter Clinical Session. Copies of all such reports are on file with the Executive Office of the Society, and with the Secretary of each component society, available for study by any member of the Society.

†Separately printed and distributed confidentially and under copyright to all Colorado State Medical Society members.

Fred Lewis, and agreed (and the Governor approved) that a committee of seven be set up, three doctors appointed by the Colorado State Medical Society President, these three to be nonpsychiatrists, two to be appointed by the Society's Mental Health Committee who will be psychiatrists, and two other members to be appointed by the Governor. This ad hoc committee of seven will study the problem of getting the community clinics integrated into the total mental health program for the State of Colorado.

The reports of the Council on Professional Relations and the Council on Public Health were presented as printed, without supplements.

The report of the Council on Scientific Education was presented as printed in the Handbook and supplemented by Dr. G. C. Milligan, Vice Chairman, who announced new dates for the Annual Session as Oct. 1-4, 1961, in conjunction with the A.M.A. Congress on Occupational Health. He also reported progress in organizing a Health Fair Committee toward possible conduct of such a Fair in Denver in late November.

Dr. Reginald Fitz presented a further supplement for the Medical Student Loan Fund Committee, analyzing student financial assistance facilities at the Medical School, the fact that the number of students applying for admission to medical schools throughout the country has decreased in recent years, and that the proportion of A students applying has decreased. At least part of this trend is due to the prolonged time and expense of an education in medicine. This problem must be met by increasing funds for nonrefundable grants in aid and scholarships and funds for long-term low interest loans. He stated that needs at the University of Colorado School of Medicine predicate at least a fourfold growth in supporting funds over the next five years. He recommended that Colorado State Medical Society members provide firm support at the regional level for students at the University of Colorado Medical School, through increased and regular contributions to the Colorado State Medical Society Medical Student Loan Fund.

Dr. S. P. Newman reported verbally as Senior Representative to the Blue Cross Board, and Dr. Harry C. Hughes reported verbally as President of Colorado Blue Shield. Both reported a successful 1960, though with many problems besetting the respective Boards of Trustees.*

These reports were referred to the Reference Committee on Insurance and Prepayment Plans.

Secretary Sethman certified that no unfinished business remained on his desk from the Annual Session and that all Boards and Councils had reported.

Dr. W. R. Lipscomb, Denver, introduced a resolution concerning the National Council of Churches, its attitude toward the A.M.A., and its indicated support of socialized medicine. The resolution called for protests to be made by physicians through their own churches. The resolution was referred to the Reference Committee on Legislation and Public Relations.

Dr. William A. Day, Colorado Springs, introduced a resolution for the El Paso County Medical Society, calling upon the Colorado State Medical Society to establish a committee, council, board, or other facility to examine the operation and evaluate the merit of any charity organization that raises money by public subscription in this state, and which has as a part of its work the furnishing of medical care, this information then to be made available to doctors and the general public, and asking delegates to the A.M.A. to initiate similar national action. This was referred to the Reference Committee on Legislation and Public Relations.

Dr. V. L. Bolton, Colorado Springs, moved that the House go on record directing the Board of Trustees of this Society to register objection to the Columbia Broadcasting System for its recent unfair handling of medical information on television. The motion was seconded and carried.

Dr. Bolton then moved that this Society go on record as expressing our views to the A.M.A. with regard to organized medicine being represented before the public by inadequately trained speakers.

Dr. I. E. Hendryson, Denver, rose to a point of order, stating that this motion calls for action before it has been considered by a reference committee.

Vice Speaker Good ruled that the motion should be referred to the Committee on Legislation and Public Relations.

Speaker Bull recognized a need for an Executive Session of the House, and on motion duly seconded and carried, the House went into Executive Session.

The House was then in Executive Session briefly where it heard confidential matters, following which Speaker Bull declared the House to be in Open Session and directed the Sergeants-at-Arms to open the doors. No final action had been taken in the Executive Session.

Secretary Sethman verified the roll call and announced that this is the biggest attendance at any meeting of this House of Delegates.

The House then adjourned at 12:30 p.m.

SECOND MEETING
Wednesday, March 1, 1961

The House reconvened at 4:30 p.m. The initial roll call disclosed 81 accredited members of the House present (later in the meeting this was revised to 84).

Upon motion duly made, seconded and carried, the reading of the condensed minutes of the First Meeting of Tuesday, February 28, 1961, was dispensed with.

*See report of Reference Committee on Insurance and Prepayment Plans, page 61, col. 1.

Speaker Bull introduced Mr. Frank K. Woolley, field representative of the A.M.A., who addressed the House briefly to outline the A.M.A.'s position in opposition to the present effort in Congress to place health care for the aged under Social Security, which has been introduced by Congressman King of California, Bill No. HR 4222.

Dr. John C. McAfee, Denver, after prefacing remarks by Dr. Irvin Hendryson, Denver, introduced a resolution concerning an inaccurate Scripps-Howard release by one of its science writers, published the same day in the Rocky Mountain News and indicating that the answer (criticizing unfavorably the Salk antipolio vaccine) of a scientific consultant to the question of an anonymous physician in the Question and Answer Section of the J.A.M.A., was the official opinion of the A.M.A., which it was not. The resolution concluded as follows:

"BE IT RESOLVED, That the Colorado State Medical Society recommends to the officers of the A.M.A. that the Scripps-Howard Syndicate be advised of the above facts, and recommends that they should demand of the Scripps-Howard Syndicate public retraction of the misrepresentations of this release; that a copy of this resolution be submitted to the local news agencies for publication, so that the people of this state may be assured that the Salk vaccine has been proved to be effective as officially reported by the A.M.A. House of Delegates; that the opinion of the efficacy of this vaccine by the medical profession has not been altered by this newspaper article, and that this Society continues to advocate and urge immunization for poliomyelitis with this vaccine, on the widest possible scale."

On motion by Dr. McAfee, seconded by several delegates, the resolution was unanimously adopted.

President Cyrus W. Anderson presented a supplemental report of the Board of Trustees noting (1) a need for more responsibility on the part of certain component society secretaries, (2) that the Board is seeking dismissal of all remaining parts of the suit against the Las Animas County Medical Society which was filed three years ago by certain UMWA-retained physicians, and (3) is asking the A.M.A. to undertake further legal action in this connection.

At the request of the Board of Trustees, Dr. Kenneth C. Sawyer discussed in detail his and Dr. Myron Waddell's attendance at the Annual Congress on Medical Education and Licensure held recently in Chicago.

President Anderson amplified the Trustees' Report with a plea that, instead of appointing or electing the newest member of a county society as Secretary, to give this office to a man who perhaps has been President, or one of the older members in the society, because it is a very important job.

On motion, duly seconded and carried, the supplemental report of the Board of Trustees was then adopted.

Reports of reference committees

Reference committees reported as follows, in each case the reports being adopted by the House without dissent, section by section, and then as a whole unless otherwise noted.

Reference Committee on Board of Trustees and Executive Office

This committee (Drs. Milton L. Wiggins, Chairman; V. A. Brumbaker, Vice Chairman; T. W. Halley, Robert W. Ludwick, and J. Robert Spencer) approved the report of the Board of Trustees as printed in the Handbook except for a paragraph on page 11 reporting the Society's loss of "nonprofit organization" status insofar as third-class mailing privileges are concerned, the committee noting that subsequent to printing the Handbook the Post Office Department in Washington had reversed the local Post Office finding and had reinstated the Society's privileges, thus saving the Society about one-half of its third-class mailing costs.

The committee approved the report of the Executive Secretary as printed in the Handbook noting, however, that since the printing, most of the suit against the Las Animas County Medical Society by certain Trinidad physicians associated with the UMWA Welfare Fund has been dismissed.

The committee commended the Executive Secretary for the clarity and validity of his special supplemental report presented verbally to the House, approved the report, and urged the Board of Trustees to distribute it to each member of CSMS after any necessary editing. Regarding six specific recommendations in the Executive Secretary's supplemental report the reference committee added four recommendations of its own.*

The committee recommended approval of recommendations of the Council on Professional Relations printed on page 30 of the Handbook related to Woman's Auxiliary finances, but this section of the reference committee report was amended by motion from the floor of the House to coincide with the action of the Board of Trustees as printed in the third paragraph on page 10 of the Handbook.

As so amended the reference committee report was adopted as a whole.

*Separately printed and distributed to all CSMS members with the original report.

Reference Committee on Legislation and Public Relations

This committee (Drs. Vernon L. Bolton, Chairman; William R. Lipscomb, Vice Chairman; George C. Christie, John B. Farley, and Samuel P. Newman) approved the printed report of the Council on Governmental Relations, its mimeographed supplement previously distributed, and the verbal supplement presented by Dr. Bradford Murphey, highly complimenting the Council for its excellent work.

The committee approved paragraph 1 of the report of the Council on Medical Service as printed, urging each hospital staff to form an admission and discharge committee, with the reference committee cautioning all persons concerned with implementing these objectives regarding the necessity of exercising thoughtful and judicious care in the discharge of their duties.

The committee approved that section of the printed report of the Council on Public Health beginning on page 31 and including most of page 32 of the Handbook which had been referred to this reference committee, except for the last full paragraph on page 32 concerned with the report of the Rehabilitation Committee.

The committee referred to the Board of Trustees, without further House action, the motion of the El Paso County Medical Society requesting a protest to the A.M.A. concerning inadequate representation of the A.M.A. on certain public programs.

The committee amended a resolution submitted by the El Paso County Medical Society and recommended its adoption to read as follows:

"That the Colorado State Medical Society establish a facility to examine the operation of any charity organization that raises money by public subscription in this state and which has as a part of its work the furnishing of medical care; and further to keep such information on file in the State Society's Executive Offices where it will be available upon request by physicians or the public."

The committee referred to the Board of Trustees without further House action the resolution submitted by Dr. William R. Lipscomb regarding the National Council of Churches, with authority for the Board to take whatever action it deemed suitable.

The committee amended, and recommended approval as amended, the resolution submitted by Dr. Robert P. Harvey calling upon the Society to abandon the term "socialized medicine" and to substitute the term "compulsory governmental medicine," and to urge the A.M.A. to do the same. The committee approved the following Proposal No. 2 in the same resolution:

"Supplementing the activities of the American Medical Association, that the Colorado State Medical Society immediately establish means of publicizing to the population of the State of Colorado the dangers inherent in replacing the present system of medical care with the compulsory one. That this be done by utilizing all available means at our disposal (radio, television, newspapers, movies, strips, slides, cartoons, public relations, office materials, leaflets, pamphlets, contacting other professional groups) most especially the establishment of properly chosen teams for debating and speaking engagements before public and civic groups throughout the state, and that full advantage be taken of the facilities and material from the American Medical Association and other bodies."

Proposals Nos. 3 and 4 of the same resolution were amended by the committee to read as follows:

"That the Board of Trustees exercise vigorous action in the utilization of present facilities in implementing the Proposal numbered 2 (next above). They are further urged to take such other action as they find necessary to carry out the above intent."

The reference committee considered a resolution on the Old-Age Pension program, also presented by Dr. Harvey, and approved recommendation No. 1 in that resolution as follows:

"That the Colorado State Medical Society and its individual members reaffirm its intent and desire to obtain and deliver to all people, regardless of segment, the best possible available medical care and will continue to cooperate in the proper operation of the old age pension medical care program."

The reference committee rewrote and approved the remaining recommendations of the resolution as follows:

"We suggest that certain conclusions drawn and publicized making it appear that physicians are solely responsible for the program's operation and difficulties were made without documentation."

"That the Colorado State Medical Society and its individual members continue to actively assist in the establishment and implementation of such measures (including admission and discharge committees) previously recommended as will insure proper care and hospitalization of all patients, including the aged, in need of same, and to see that such stay is not unduly prolonged."

"That the public, the Welfare Department, and the Governor be apprised when we become aware of reducible costs in the program in order to further the best economic pattern."

"That an effective and continuing educational program for pensioners, their relatives and friends, members of the County and State Welfare Departments, and other interested parties be developed and recommended to the State Welfare Department for implementation, since we feel it is their responsibility."

"That physicians do their utmost toward providing for prompt extension of needed hospital benefits and transfer from hospital to nursing homes."

"That it be more effectively emphasized to the public that the Old Age Pension program is not a Blue Cross-Blue Shield plan, that the latter plans have no direct nor financial interest in the Old Age Pension program, but act as fiscal agents purely in the public interest. We again request that the State Welfare Department and the Blue Cross-Blue Shield individuals who are administering this fund be urged to join with us in the dissemination of this information."

As so amended the above resolutions were adopted.

Reference Committee on Insurance and Prepayment Plans

This committee (Drs. Jess H. Humphries, Chairman, Samuel B. Childs, Vice Chairman, William F. Barrows, Sidney E. Blandford, and William S. Curtis) approved paragraph 2 of the Council on Medical Service as printed, including the supplement presented verbally by the Blue Shield Advisory Committee.*

The committee approved the verbal report of Dr. H. C. Hughes, President of Blue Shield, which the committee condensed as follows:

"1. He announced the four new members of the Blue Shield Board elected Feb. 11, 1961.

"2. He reported on wide acceptance in Colorado of the Blue Cross-Blue Shield plans as offered to federal employees under the federal employee health benefit program.

"3. He described the limited agreement which has been made with the Chiropodists for a one-year trial period.

"4. Representing the Blue Shield Board he requested authority for the plan to offer a new service benefit contract in the interest of national Blue Shield uniformity, the details of which were carried in his report. This would be for the benefit of companies with employees in more than one state.

"5. He reported on a new fee schedule for in-hospital nonsurgical care that will be put on a six-month trial basis."

The committee particularly commended both Blue Shield and the Colorado Society internists concerning item No. 5 above.

The committee approved the report of Dr. Samuel P. Newman for the Blue Cross Board, called attention to his advice regarding admission and discharge committees, reminding such committees that they should deal with doctors, not with patients, because, quoting Dr. Newman, "legally the attending physician has the responsibility for the medical decisions and welfare of the patient."

The reference committee recommended that the Council on Medical Service, jointly with the State Welfare Department, Hospital Association, Blue Shield, Blue Cross, and legal counsel, develop a plan of procedure for admission and discharge committees which should include general rules for guidance of doctors in hospitals.

Reference Committee on Scientific Work and Remaining Business

This committee (Drs. William A. Liggett, Chairman; Robert B. Richards, Vice Chairman; Kenneth Gloss and Edward S. Miller) approved all sections of the printed report of the Council on Public Health referred to this committee, and further approved the verbal supplemental report by Dr. Bradford Murphey, already approved by another reference committee. The reference committee specifically approved all recommendations of the Tuberculosis Control Committee printed in the Handbook.

The committee approved the report of the Council on Scientific Education as printed and as supplemented regarding the Student Loan Fund Committee, urging all CSMS members to contribute to student loan funds of their choice.

The committee approved the supplemental report concerning the development of a Health Fair and urged creation of a finance liaison committee from the Board of Trustees to work out financial details of the proposed Health Fair.

Reference Committee on Professional Relations

This committee (Drs. William M. Covode, Chairman; Adrian Baer, Robert N. Humphrey and William R. Sisson) approved the reports of the Judicial Council and the Grievance Committee, and congratulated both bodies on the minimal need for disciplinary actions in the last six months.

The committee approved the report of the A.M.A. delegation and urged all members to read that report printed in the February, 1961, Rocky Mountain Medical Journal.

The committee commended the Council on Professional Relations and its contact with Rocky Mountain medical groups, and approved the Council's printed report except for the first paragraph on page 29 of the Handbook concerning the report of the Insurance Committee, the reference committee recommending that this material be received for information only, with no endorsement by the Society.

There was no unfinished business to be presented, and no delegate submitted new business, and Speaker Bull then declared the House adjourned sine die.

The foregoing abstract of minutes of the House of Delegates for the 26th Midwinter Clinical Session is respectfully submitted to the Society.

HARVEY T. SETHMAN,
Secretary, House of Delegates.

*See page 54, column 2.

MONTANA

Proceedings of the House of Delegates Montana Medical Association

Special Meeting
January 8, 1961
Great Falls

The special meeting of the House of Delegates of the Montana Medical Association was called to order by Harold W. Fuller, M.D., Vice President, at 1:00 p.m., January 8, in the Carter Room of the Rainbow Hotel, Great Falls.

The Secretary, W. E. Harris, M.D., announced that all delegates seated had presented proper credentials and that a quorum was present.

The following members were then seated as delegates by motion to represent the component societies indicated:

Garl L. Hale, M.D., Flathead County Medical Society; A. L. Vadheim, Jr., M.D., Gallatin County Medical Society; T. L. Hawkins, M.D., Everett H. Lindstrom, M.D., Philip D. Pallister, M.D., Lewis and Clark Medical Society; H. D. Rossiter, M.D., Silver Bow County Medical Society; S. C. Pratt, M.D., Southeastern Montana Medical Society; David W. Chase, M.D., Western Montana Medical Society; William E. Butler, M.D., Matthew W. Calvert, M.D., Wayne M. Roney, M.D., R. E. Smalley, M.D., Yellowstone Valley Medical Society.

Dr. Fuller announced that this special meeting of the House of Delegates had been called to consider and to act upon the proposals of the Executive Committee and of the State Board of Medical Examiners for the amendment of the Medical Practice Act during the current session of the Legislative Assembly of Montana. Dr. Fuller explained that the proposed revisions to the Medical Practice Act will include those recommended by the State Board of Medical Examiners to permit licensure of graduates of foreign medical schools. to increase the fees for licensure by examination and by reciprocity, and to increase the annual registration fees for physicians licensed to practice in Montana. The proposed amendments, in addition, Dr. Fuller reported, will provide for the modernization of the Medical Practice Act of Montana and will permit the practice of medicine and surgery by graduates of schools of osteopathy under clearly specified limitations and after examination by the State Board of Medical Examiners. The proposed amendments will also include provisions for the repeal of the Thompson Act under the criminal sections of Montana statutes.

Mr. Melvin Magnuson, legal counsel of the State Board of Medical Examiners, Everett H. Lindstrom, M.D., chairman of the Liaison Committee of this Association, and Amos R. Little, Jr., M.D., chairman of the Legislative Committee of this Association, explained the salient features of the suggested amendments to the Medical Practice Act as well as the reasons for suggesting these amendments.

Motions of the House

Following these presentations, many proposals for amendment of the Medical Practice Act were fully discussed by members of the House. After this lengthy discussion, the following motions were presented for official consideration by the members of the House of Delegates and the action indicated was taken by it upon each of these motions:

It was moved that this House of Delegates go on record as favoring the proposals of the Board of Medical Examiners to:

1. Change the date of the examinations for licensure from April and October to January and July;

2. Increase the fees for licensure by examination and by reciprocity and to increase the fees for annual registration of licenses;

3. Increase the per diem allowances paid to members of the Board of Medical Examiners for the time spent in the discharge of their duties;

4. Provide for licensure by examination for the citizen who is a graduate of a foreign medical school which meets the minimum educational requirements;

5. Amend the provisions of the present law relating to the revocation and/or suspension of licenses to practice medicine.—Motion carried.

It was moved that the House of Delegates support the Executive Committee in the principles that it has enunciated regarding the proposed amendments to the Medical Practice Act. As a substitute motion, however, it was moved that the House of Delegates go on record as opposing any changes in the Medical Practice Act of Montana which propose to amend the present statutes relative to the practice of osteopathy, chiropractic, or any other cultist belief or practice that concerns the healing arts.—Substitute motion carried after a roll call vote.

It was moved that the House of Delegates request the Committee on Legislation of this Association through its legal counsel to introduce as an amendment to the Medical Practice Act a provision that no license tax shall be imposed upon physicians and/or surgeons by a municipality or any other subdivision of the state.—Motion carried.

It was moved that the House of Delegates express its willingness to accept legislation which will repeal the Thompson Act but that it express its opposition to any change in the Hospital Licensing Act under the civil statutes.—Motion failed to carry.

Following these actions, several members of the House of Delegates recommended that the appropriate committee of this Association continue to study the proposals of the Executive Committee,

the State Board of Medical Examiners, and the Liaison Committee of this Association and that the conclusions and recommendations of these groups be presented for consideration and action by each of the component medical societies of this Association during 1962. This suggestion, however, was not presented as a motion and, therefore, no action was taken upon it by the House of Delegates.

The chairman of the Legislative Committee, Amos R. Little, Jr., M.D., then discussed for the information of the members of the House of Delegates the probable expenses of the current session of the Legislative Assembly of Montana and indicated that the expense of promoting or opposing legislation may well exceed the funds available during the current year. As a result of this discussion, it was moved that the Executive Committee be authorized to levy an assessment of not more than $25 per member for purposes of publicity and education if additional funds are required for the legislative program of this Association. This motion was seconded and after a very brief discussion, carried.

Dr. Fuller then announced that the business included in the call for this special meeting had been completed. He thanked the members of the House of Delegates for their attendance and assured them that the members of the Executive Committee and of the Legislative Committee would do their best to carry out the wishes and instructions of the House of Delegates.

There being no further business, this special meeting of the House of Delegates adjourned at 4:45 p.m.

The following delegates, alternate delegates, and members of this Association were present at this special session of the House of Delegates:

CASCADE COUNTY MEDICAL SOCIETY: Alan B. Bond, M.D., Great Falls; James J. Bulger, M.D., Great Falls; Paul R. Ensign, M.D., Great Falls; George B. Eusterman, Jr., M.D., Great Falls; Harry V. Gibson, M.D., Great Falls; John R. Halseth, M.D., Great Falls; John C. Hanley, M.D., Great Falls; Robert J. Holzberger, M.D., Great Falls; F. D. Hurd, M.D., Great Falls; John A. Layne, M.D., Great Falls; Harry W. Power, M.D., Great Falls; Charles H. Steele, M.D., Great Falls; William E. Sullens, M.D., Great Falls; Robert M. Addison, M.D., Great Falls; F. Hughes Crago, M.D., Great Falls; Frank J. Friden, M.D., Great Falls; Donald C. Overy, M.D., Great Falls.

FERGUS COUNTY MEDICAL SOCIETY: John W. Schubert, M.D., Lewistown.

FLATHEAD COUNTY MEDICAL SOCIETY: Garl L. Hale, M.D., Kalispell; E. P. Higgins, M.D., Kalispell.

GALLATIN COUNTY MEDICAL SOCIETY: Alan Iddles, M.D., Bozeman; C. A. Kirkpatrick, M.D., Bozeman; Edward J. Purdey, M.D., Bozeman; A. L. Vadheim, Jr., M.D., Bozeman.

HILL COUNTY MEDICAL SOCIETY: Richard S. Buker, Jr., M.D., Chester; C. W. Lawson, M.D., Havre.

LEWIS AND CLARK MEDICAL SOCIETY: David P. Findley, M.D., Helena; T. L. Hawkins, M.D., Helena; Raymond O. Lewis, M.D., Helena; Everett H. Lindstrom, M.D., Helena; Amos R. Little, Jr., M.D., Helena; Philip D. Pallister, Boulder.

MOUNT POWELL MEDICAL SOCIETY: None.

NORTHCENTRAL MONTANA MEDICAL SOCIETY: Porter S. Cannon, M.D., Conrad; Edward L. King, M.D., Browning.

NORTHEASTERN MONTANA MEDICAL SOCIETY: David Gregory, M.D., Glasgow; Mark B. Listerud, M.D., Wolf Point.

PARK-SWEETGRASS MEDICAL SOCIETY: W. E. Harris, M.D., Livingston; George J. Moffitt, M.D., Livingston.

SILVER BOW COUNTY MEDICAL SOCIETY: H. D. Rossiter, M.D., Sheridan.

SOUTHEASTERN MONTANA MEDICAL SOCIETY: S. C. Pratt, M.D., Miles City; Edwin L. Stickney, M.D., Miles City; O. A. Swenson, M.D., Sidney; J. R. Thompson, M.D., Miles City.

WESTERN MONTANA MEDICAL SOCIETY: Leonard W. Brewer, M.D., Missoula; David W. Chase, M.D., Missoula; John A. Evert, M.D., Missoula; E. K. George, M.D., Missoula.

YELLOWSTONE VALLEY MEDICAL SOCIETY: W. A. Armstrong, M.D., Billings; P. M. Berg, M.D., Billings; M. W. Calvert, M.D., Laurel; Herbert T. Caraway, M.D., Billings; B. G. Hughett, M.D., Billings; Sidney J. Hayes, M.D., Billings; James D. Morrison, M.D., Billings; E. C. Segard, M.D., Billings; Wayne M. Roney, M.D., Billings; R. E. Smalley, M.D., Billings; Charles C. Morledge, M.D., Billings; C. H. Swanson, Jr., M.D., Columbus; William E. Butler, M.D., Billings.

Organization continued on page 68

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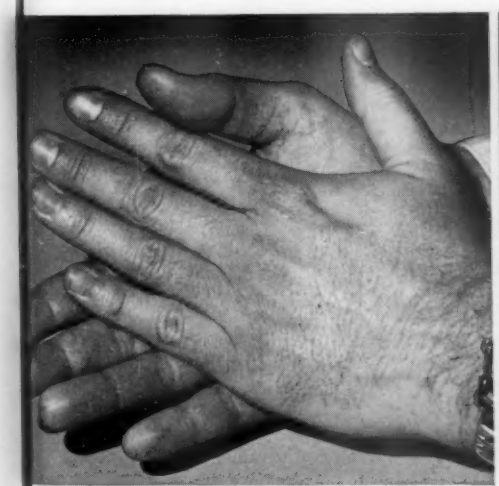

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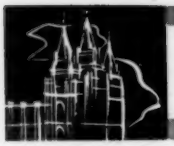


UTAH

Obituary

EZEKIEL R. DUMKE

Ezekiel R. Dumke, M.D., a prominent and retired Ogden physician and surgeon, died in the Iron County Hospital at Cedar City Tuesday, March 21, of a coronary occlusion. He was returning with Mrs. Dumke to Ogden from an extended trip throughout this country and Mexico.

Born in Manitowoc, Wisconsin, he was the son of John F. and Ida Ricker Dumke. Receiving his M.D. degree from Northwestern University, Dr. Dumke interned at St. Anthony's Hospital in Denver and the Latter Day Saints Hospital in Salt Lake City. In 1915 he became associated with Dr. Ezra Rich in Ogden. He married Edna Wattis in Ogden on June 25, 1917.

Among his many accomplishments was pioneering the use of spinal anesthesia. He was also the first physician to use calcium in treating the bite of the black widow spider, and was recognized as an authority in thyroid surgery.

He also helped to organize the Ogden Surgical Society in 1946, and was most influential in establishing St. Benedict's Hospital. He was its Chief of Staff for two years as well as Chief of Staff at the Thomas D. Dee Memorial Hospital. As Director of the E. O. Wattis Foundation and of the E. R. and Edna Wattis Dumke Foundation, he was credited with helping young doctors through their early years of practice.

Dr. Dumke was a member of the American Medical Association, the American Thyroid Society, the Society for the Study of Trauma, Southwest Surgical Society, and the Pan American Doctors Association. He was a past President of the Utah State Medical Association, the Weber County Medical Society, Ogden Surgical Society, and was a two-term Governor of the Utah Chapter of the American College of Surgeons.

WYOMING

Physicians delivering 100 or more infants

The Wyoming Department of Public Health has released its annual list of Wyoming physicians delivering 100 or more live babies in the preceding year. The figures are for the calendar year 1960, and the list includes 13 physicians.

1. Travis, Bane T., Cheyenne.....352
2. Shwen, Ralph O., Cheyenne.....272
3. Bowden, Robert H., Casper.....264
4. Young, Clarke M., Casper.....263
5. Sullivan, Bernard J., Laramie.....194
6. Schleyer, Otis, Cheyenne.....166
7. Knox, William R., Sheridan.....150
8. Tipton, Harry B., Lander.....139
9. Harrison, G. Myron, Rock Springs.....136
10. Seisler, E. P., F. E. Warren AFB.....133
11. Pyrich, William V., Rock Springs.....106
12. Engelman, A. A., Worland.....105
13. Richards, Eugene W., Riverton.....101

Maternal Mortality cont. from page 40

Autopsy findings were: acute endometritis, sero-sanguinous peritoneal effusion, bilateral pleural effusion, bilateral pulmonary edema, atelectasis of both right and left lower lobes, jaundice and congestion of all viscera and lower nephron nephrosis.

Comment

The committee felt that three factors were contributory to the death of this patient. First, the performance of curettage when signs and symptoms of peritonitis were already evident. Second, the delay in institution of treatment for the infection. Third, failure to use cortisone. It was the opinion of the committee that this death was preventable.

Medical history of war offered

Many of the medical lessons learned during World War I had to be relearned under fire during World War II because of paucity of distribution of the World War I medical history.

Lieutenant General Leonard D. Heaton, the Army Surgeon General, in an endeavor to prevent this costly relearning process, in the unhappy event of another war, has directed the preparation, publication, and distribution of the "History of the Medical Department, United States Army, in World War II." General Heaton is particularly anxious that information of the existence and availability of this history be circulated widely among the profession, both military and civilian.

Of the 48 volumes programmed for the series, 15 have been published and can be purchased at modest cost from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. The set of 15 volumes may be purchased for $66.50 or individual volumes can be obtained at remarkably low prices. Commanding officers of medical units may requisition copies for their Medical Units libraries by submitting DA Form 17 directly to the Historical Unit, U. S. Army Medical Service, Washington 12, D. C., Attn. Promotion Branch.

Volumes now available are:

"General Surgery," edited by Michael E. DeBakey, M.D.

"Neurosurgery," Volume I (Head Injuries), edited by R. Glen Spurling, M.D., and Barnes Woodhall, M.D.

"Neurosurgery," Volume II (Spinal Cord and Peripheral Nerve Injuries), edited by R. Glen Spurling, M.D., and Barnes Woodhall, M.D.

"Hand Surgery," edited by Sterling Bunnell, M.D.

"Ophthalmology and Otolaryngology," edited by M. Elliott Randolph, M.D., and Norton Canfield, M.D.

"Orthopedic Surgery, European Theater of Operations," edited by Mather Cleveland, M.D.

"Orthopedic Surgery, Mediterranean Theater of Operations," by Oscar P. Hampton, M.D.

"Physiologic Effects of Wounds," edited by Fred W. Rankin, M.D., and Michael E. DeBakey, M.D.

"Vascular Surgery," edited by Daniel C. Elkin, M.D., and Michael E. DeBakey, M.D.

"Cold Injury, Ground Type," by Tom F. Whayne and Michael E. DeBakey, M.D.

"Dental Service," George F. Jeffcott, D.M.D.

"Environmental Hygiene," by James Stevens Simmons, M.D., and others.

"Personal Health Measures and Immunization," by John E. Gordon, M.D., Tom F. Whayne, M.D., and others.

"Communicable Diseases," Volume IV, by John E. Gordon, M.D., Joseph Stokes, M.D., and others.

"Hospitalization and Evacuation, Zone of Interior," by Clarence McKittrick Smith.

MEDICAL SCHOOL NOTES

Project HOPE film available

A story of medical training and teaching in Southeast Asia is depicted in a new and dramatic 27-minute color motion picture documentary made available by Project HOPE. The film, "Voyage of the SS HOPE," tells the story of the American people's floating medical center currently in Indonesia.

The story line is that of the SS HOPE I, a former U. S. Navy hospital ship converted to a floating medical school through the contributions of the American people. The SS HOPE is the principal vehicle of the People-to-People Health Foundation, Inc., 1818 M Street, N.W., Washington 6, D. C.

The film tells the story of the dedicated American medical men and women who make up the permanent and volunteer rotating staff of the medical vessel. It shows them at work, and alongside the Americans are their Indonesian counterparts, learning and working together. Produced for Project HOPE by Ex-Cell-O Corp., the half-hour film is narrated by Bob Considine, nationally

known newspaperman, feature columnist and radio and television commentator.

The documentary is available for interested groups and television showings. Inquiries may be directed to: Film Department, Project HOPE, 1818 M Street, N.W., Washington 6, D. C.

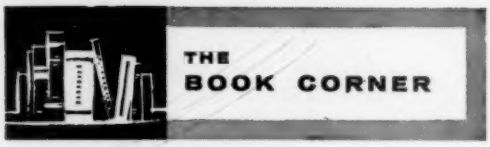
Washington Scene cont. from page 47

and occasional basis and after they had been put on the market.

The government is spending $4.1 billion a year in the health field, a Senate Government Operations Subcommittee reported. In the most detailed report of its kind ever published by a governmental group, the subcommittee, headed by Sen. Hubert Humphrey (D., Minn.), noted that $1.1 billion of the total cares for sick members of the armed forces and their dependents in hospitals. The tab for Civil Service workers' sick leave totals $315 million a year. About $650 million a year is spent on medical research, with most of this carried out by the National Institutes of Health and the Veterans Administration.

The government ordered 250 physicians drafted this year due to the failure of enough interns to sign up for military service. It is the first physicians draft in four years. All of the draftees will be assigned to the Air Force. A department spokesman said the draft call would not prevent individual physicians finishing internship this year from volunteering for Air Force medical duty.

"Step right over here, sir, this is where we cure slight cases of the sniffles!"



New books received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Rypin's Medical Licensure Examinations: Edited by Walter L. Bierring, M.D., M.A.C.P., M.R.C.P. 9th ed. Philadelphia, Lippincott, 1960. 805 p. Price: $11.00.

Occupational Diseases and Industrial Medicine: By Rutherford T. Johnstone, M.D., and Seward E. Miller, M.D. Philadelphia, Saunders, 1960. 482 p. Price: $12.00.

A Polychrome Atlas of the Brain Stem: By Wendell J. S. Kreig. Evanston, Ill., Brain Books, 1960. Unpaged. Price: $3.00.

Outline of Pathology: By John H. Manhold, Jr., D.M.D., M.A., F.A.C.D., and Theodore E. Bolden, D.D.S., M.S., Ph.D. Philadelphia, Saunders, 1960. 340 p. Price: $4.75.

Adventure to Motherhood; the Picture-Story of Pregnancy and Childbirth: By Allan J. Offen, M.D. Miami, Fla., Audio-Visual Educ. Co., 1960. Unpaged. Price: $2.95.

Sight; a Handbook for Laymen: By Roy O. Scholz, M.D. Garden City, Doubleday, 1960. 166 p. Price: $3.50.

Obstetrics: By J. P. Greenhill, M.D., F.A.C.S., F.I.C.S. 12th ed. Phiadelphia, Saunders, 1960. 1098 p. Price: $17.00.

Complications in Surgery and Their Management: Edited by Curtis Artz, M.D., F.A.C.S., and James D. Hardy, M.D., F.A.C.S. Philadelphia, Saunders, 1960. 1075 p. Price: $23.00.

Protein and Amino Acid Requirements in Early Life: By L. Emmet Holt, M.D., and others. New York, New York University Press, 1960. 63 p. Price: $1.00.

A System of Medical Hypnosis: By Ainslie Meares, M.D., B. Agr. Sc., D.P.M. Philadelphia, Saunders, 1960. 484 p. Price: $10.00.

Care of the Well Baby; Medical Management of the Child from Birth to Two Years of Age: By Kenneth S. Shepard, M.D. Philadelphia, Lippincott, 1960. 224 p. Price: $3.25.

Contributions to Obstetrics and Gynaecology: By V. N. Shirodkar, M.D., F.R.C.S., F.A.C.S. Edinburgh, Livingstone, 1960. 159 p. Price: $8.50.

Fundamentals of Chest Roentgenology: By Benjamin Felson, M.D. Philadelphia, Saunders, 1960. 301 p. Price: $10.00.

Book reviews

Ciba Foundation Symposium on Congenital Malformations. Boston, Little, Brown and Company, 1960.

Physicians interested in congenital disturbances would do well to read this small volume which, in fact, is a collection of the minutes of a recent symposium on the subject of congenital abnormalities recently held at the invitation of the Ciba Foundation. Authorities from all over the world contributed original papers and participated in the discussions.

The publishers on the cover flap state that the publication, it is hoped, "will help to fertilize, organize and bring to maturity a world-wide effort to eliminate many of these avoidable calamities."

I think the book would be even more valuable if some competent authority would add a final chapter summarizing the contents of the volume.

O. Philpott, M.D.

Breast Cancer: 2nd Biennial Louisiana Cancer Conference: By Albert Segaloff. Mosby, 1958.

This is an exceptionally well edited book which covers the subject material of the Second Biennial Louisiana Cancer Conference which was devoted to breast cancer. Every phase of the broad subject regarding cancer of the breast is covered by an authority, followed by a panel discussion of different viewpoints regarding not only the pathology and treatment of cancer of the breast, but also its biology and epidemiology. Each phase of this study is discussed by a well known authority in the field. Steroid and hormonal management of the patient with carcinoma of the breast is presented in great detail, and answers many of the questions that have been posed regarding this form of therapy. Radiation therapy and ultra-radical surgical attacks are thoroughly discussed by a well qualified panel. I feel that everyone who is treating patients with carcinoma of the breast will gain a great deal of useful information from this treatise.

Robert E. McCurdy, M.D.

Medicine Today: A Report on a Decade of Progress: By Marguerite Clark. New York, Funk & Wagnalls, 1960.

As a medicine editor of Newsweek, the author shows great skill in narrating the many recent advances in medicine. She does the job in a more lucid fashion for the layman than the scientist is usually able to.

References are always given for the source of her report and, thus, science reporting is kept within appropriate bounds.

The author is thus ranked with Paul deKruif as an effective reporter of the medical world.

W. L. Chadwick, M.D.

Communicable and Infectious Diseases: By Franklin H. Top, M.D. St. Louis, 4th ed. C. V. Mosby Co., 1960.

This volume remains a reference item in matters of the diagnosis, prevention and treatment of infectious disease. Dr. Top exercises his editorial prerogative in keeping the format nicely clinical in approach. The collaborators are authorities of established reputation and put the emphasis where it is deserved in preventive medicine.

The new edition is indeed brought up to date in its coverage of infectious diseases.

Ward L. Chadwick, M.D.

Christopher's Minor Surgery: Edited by Alton Ochsner and Michael E. DeBakey. 8th ed. Phila., W. B. Saunders Co., 1959. 117 p.

This represents another edition of a famous teaching text on some surgical subjects. The title of "Minor Surgery" is deceiving in that much of the material is in reality basic surgical information necessary to any surgical understanding or effort, major or minor. The purpose of the text is to provide essential facts of surgical treatment in the emergency room or office. This must include

a discussion of diagnosis and pathogenesis, as well as just therapeutic technics.

The book deals with fundamentals, including such subjects as sterilization procedures, as well as detailed lists of instruments for specific surgical procedures. The beginner must start with this type of information.

The section on anesthesia, by John Adriani, includes both general and local anesthetic technics. There are many excellent chapters, each contributed by members of surgical specialties, and special interests, as contrasted to the earlier edition of this text.

Part III on the Musculoskeletal System is brief and incomplete. Special comment should be made on the excellent chapter, The Surgical Resident, by Frederick Fitzherbert Boyce. Tradition has in the past directed the resident in his relationship to the specialty, hospital patient and attending surgeon. Dr. Boyce, fortunately, puts some of his thoughts on this subject in writing, something rarely done in formal texts.

The intern, more so than the medical student, and the surgical resident should have ready access to this book. Those who already own an earlier edition of this text will find the Eighth Edition almost completely new, less comprehensive, but organized differently into systems so that it is more readable and, consequently, more functional.

John D. Leidholt, M.D.

Heritable Disorders of Connective Tissue: By Victor A. McCusick, M. D. St. Louis, C. V. Mosby Co., 1960. 319 p.

Disorders of connective tissue are the concern of many medical specialties, the pediatrician, internist, rheumatologist, orthopedist, and others. This collection of invaluable clinical material will be welcomed by all who were not familiar with it. Only by review of the medical literature can this information be obtained. In this second edition over 80 illustrations and 130 pages have been added. An up-to-date bibliography is provided.

The heritable disorders of connective tissue are rare. This book should serve as a ready reference for the clinician, but should serve as a source of data for the investigator. John D. Leidholt, M.D.

Manual of Skin Diseases: By Gordon C. Sauer, M.D.

This diffusely illustrated and compact text on the subject of general dermatology is admirably suited to the needs of the busy general practitioner, internist, or pediatrician. The main clinical and diagnostic features of this specialty are well covered through the medium of numerous black and white, as well as colored, photographs which, for the most part, are well chosen to depict the lesions being discussed. The latter are presented succinctly in outline form.

One of the outstanding features of this book is the combined dictionary and index, which occupies 32 pages. This section alone should prove

continued on page 76

"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

FOR FULL INFORMATION SEE YOUR SQUIBB PRODUCT REFERENCE OR PRODUCT BRIEF.

The book corner cont. from page 73

quite valuable and time-saving to the practitioner not too well versed in the frequently confusing terminology encountered in dermatology.

Glenn E. McCormick, M.D., Denver

Dr. Schmidt's Baby Name Finder: By J. E. Schmidt, M.D. Springfield, Thomas, 1960. 390 p.

This book, by Dr. Schmidt, is a mildly interesting work, which deals with the semantics of first names.

The introduction states that the purpose of the book is to "enable parents-to-be to select a suitable name on the basis of some virtue of desirable characteristic."

If this purpose is fulfilled, some currently popular names such as "George" (earthworker) will likely fade into oblivion while other more obscure names, such as "Hypatia" (feminine combination of intellectual prowess and physical beauty), "Daria" (possessing wealth) and "Virgil" (a man of authority) should enjoy new popularity.

The real value of the book seems to lie in its long lists of feminine and masculine names, which should provide new parents or prospective parents ample material for argumentation and debate concerning what to name their new "Fedora" (gift of God).

V.H.V.

The Reluctant Surgeon; a Biography of John Hunter: By John Kobler. Garden City, Doubleday, 1960. 359 p. Price: $.95.

This is a remarkable biography of "the founder of scientific surgery," John Hunter, who lived and practiced in 18th Century London. He was a gruff, eccentric Scotsman, whose supreme genius brought medicine out of the Dark Ages. He became a pioneer in countless fields of science. He was generations ahead of his time and was probably the greatest dissector and collector of anatomical specimens in history.

In addition to the zestful biography, the author, John Kobler, paints a vivid picture of the London of Johnson and Boswell, who frequently visited the Hunter home. Mrs. Hunter was a minor English poetess, who wrote tidy verse to Franz Joseph Haydn's music. Boswell, the infant Lord Byron, the great painters, Joshua Reynolds and Thomas Gainsborough, and Benjamin Franklin were all patients of Hunter's.

As a teacher he had enormous influence on Edward Jenner, who discovered vaccination against smallpox. He also profoundly affected the development of medicine and surgery in America through his students, John Morgan, who established the first American medical school, and Philip Physick, the "Father of American Surgery."

Hunter's greatest preoccupation was his collection of odd creatures he kept and dissected. Only with reluctance did he take time for his patients. He presented more than 50 scientific papers to the Royal Society on everything from torpedoes to the hearing of trout.

Probably what was to be his proudest experiment proved to be a deadly failure. In 1767, he infected himself with pus from a condemned criminal who had both gonorrhea and syphilis (unknown to Hunter). The gonorrhea he cured, but he eventually died of untreated syphilis. A greater tragedy, however, was that by his conclusion in his classic "Treatise on the Venereal Disease" that these two infections were the same, he set back the true knowledge of venereal disease for a generation.

This biography is well written and tells a most fascinating story of a great medical epoch.

R. W. Collett.

NATIONAL AFFAIRS

Announcement

The A.M.A. Committee on the Medical Aspects of Sports plans to present its Third National Conference on this subject in Denver, immediately preceding the Clinical Meeting, on November 26, 1961. Details concerning this conference will be announced later.

American Board of Obstetrics and Gynecology

Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, for the 1962 Part 1 Examinations are now being accepted. All candidates are urged to make such application at the earliest possible date. The deadline date for receipt of applications is August 1, 1961. *No applications can be accepted after that date.*

Candidates for admission to the examinations are required to submit their application, a plain typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application, or the year prior to their request for reopening of their application. This information is to be attested to by the Record Librarian of the hospital or hospitals and submitted on paper 8½ x 11". Necessary details to be contained in the list of admissions is outlined in the bulletin and must be followed closely.

Current bulletins outlining present requirements may be obtained by writing to the Secretary's office: Robert L. Faulker, M.D., Executive Secretary and Treasurer, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

All Diplomates of this board are requested to inform the office of the Secretary of a change of address. Your cooperation will be appreciated.

The Colorado State Medical Society

Rocky Mountain Cancer Conference, July 12-13, 1961, Denver

President: Cyrus W. Anderson, Denver.
President-elect: V. V. Anderson, Del Norte.
Vice President: Sam W. Downing, Denver.
Treasurer: William C. Service, Colorado Springs, 1962.
Constitutional Secretary: Howard T. Robertson, Denver, 1963.
Additional Trustees: Fred R. Harper, Denver, 1961; Walter M. Boyd, Greeley, 1961; Carl H. McLauthlin, Denver, 1962; J. Alan Shand, La Junta, 1963.
Delegates to the American Medical Association: E. H. Munro, Grand Junction, Dec. 31, 1961; (Alternate, Harlan E. McClure, Lamar, Dec. 31, 1961); I. E. Hendryson, Denver, Dec. 31, 1961; (Alternate, Clare C. Wiley, Longmont, Dec. 31, 1961); Kenneth C. Sawyer, Denver, Dec. 31, 1962; (Alternate, Gatewood C. Milligan, Englewood, Dec. 31, 1962).
Executive Secretary: Mr. Harvey T. Sethman, 835 Republic Building, Denver 2, Colorado; telephone AComa 2-0547.

See March, 1961, issue for complete list of committees.

Montana Medical Association

OFFICERS—1960-1961—Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1961 Annual Session.

President: Raymond F. Peterson, Fullerton, Calif.†
President-elect: Everett H. Lindstrom, Helena.
Vice President: Harold W. Fuller, Great Falls.‡
Secretary-Treasurer: William E. Harris, Livingston.
Assistant Secretary-Treasurer: Albert L. Vadheim, Jr., Bozeman.
Delegate to the A.M.A.: Paul J. Gans, Lewiston.
Alternate Delegate to the A.M.A.: S. C. Pratt, Miles City.
Executive Committee: Harold W. Fuller, Great Falls, Acting Chairman; Leonard W. Brewer, Missoula; Herbert T. Caraway, Billings; Paul J. Gans, Lewistown; William E. Harris, Livingston; Everett H. Lindstrom, Helena; S. C. Pratt, Miles City; Albert L. Vadheim, Jr., Bozeman.
Scientific Editor for Montana, Rocky Mountain Medical Journal: Perry M. Berg, Billings.
Executive Secretary: Mr. L. R. Hegland, P.O. Box 1692, Billings; telephone ALpine 9-2585.

Standing Committees

COMMITTEE ON BLOOD: V. W. Stelle, Chairman, Bozeman; Orville J. Andersen, Helena; Harold A. Braun, Missoula; Ernst J. Eichwald, Great Falls; Edward W. Gibbs, Billings; Garl L. Hale, Kalispell.
CANCER COMMITTEE: N. A. Franken, Chairman, Havre; Richard J. Best, Butte; Walter B. Cox, Missoula; Fred M. Long, Great Falls; A. J. Marchello, Billings; Warren H. Randall, Miles City; H. C. Scharnweber, Glasgow; Mary E. Soules, Helena, ex-officio.
ECONOMIC COMMITTEE: John A. Evert, Chairman, Missoula; Donald A. Atkins, Butte; Paul R. Crellin, Billings; G. O. Doherty, Missoula; Alfred M. Fulton, Billings; Donald D. Gnose, Missoula; Robert H. Leeds, Chinook; Richard L. Peterson, Hamilton; John P. Pfaff, Jr., Great Falls; Robert W. Thometz, Butte; James R. Thompson, Miles City; John C. Wolgamot, Great Falls.
FRACTURE AND ORTHOPEDIC COMMITTEE: Walter H. Hagen, Chairman, Billings; John G. Davidson, Butte; Ronald E. Losee, Ennis; William J. McDonald, Missoula; Warren J. McKinstry, Missoula; Thomas C. Power, Great Falls; Russell B. Richardson, Great Falls; G. D. Carlyle Thompson, Helena, ex-officio.
COMMITTEE ON HOSPITAL RELATIONS: S. C. Pratt, Chairman, Miles City; L. Clayton Allard, Billings; Gordon A. Anderson, Deer Lodge; Robert B. Beans, Great Falls; J. Kent Boughn, Helena; Leonard E. Kuffel, Missoula; Thomas J. Malee, Glendive; William W. McLaughlin, Havre; Edward S. Murphy, Missoula; Joseph P. Orley, Lewistown; Bernard J. Winter, Billings.
INDUSTRIAL WELFARE COMMITTEE: Howard I. Popnoe, Chairman, Great Falls; L. H. Blattspieler, Helena; William A. Burke, Butte; Clyde H. Fredrickson, Kalispell; Sterling R. Hayward, Billings; Raymond G. Johnson, Harlowton; Stuart A. Olson, Glendive; Nils T. Peterson, Billings; Scott L. Walker, Anaconda.
INTERPROFESSIONAL RELATIONS COMMITTEE: Mabel E. Tuchscherer, Chairman, Anaconda; H. M. Belen, Missoula; George J. Gelernter, Great Falls; John J. McGahan, Billings; Edward S. Murphy, Missoula; Raymond W. Polk, Miles City; Roland G. Scherer, Bozeman; Myron E. Veseth, Havre.
LEGAL AFFAIRS COMMITTEE: George G. Sale, Chairman, Missoula, 1962; Louis W. Allard, Chairman Emeritus, Billings; Robert S. Hagstrom, Billings, 1963; F. D. Hurd, Great Falls, 1961; Chester W. Lawson, Havre, 1963; James J. McCabe, Helena, 1961; F. L. McPhail, Great Falls, 1961; Emmet A. Mechler, Kalispell, 1962; Thomas W. Saam, Butte, 1963; John W. Schubert, Lewistown, 1962.
Subcommittee on Coroner's and Medical Examiner's Laws: John P. Pfaff, Jr., Chairman, Great Falls; Orville J. Andersen, Helena; Charles E. Magner, Great Falls; George G. Sale, Missoula; Edwin C. Segard, Billings.
LEGISLATIVE COMMITTEE: Amos R. Little, Jr., Chairman, Helena; John R. Burgess, Co-chairman, Helena; William F. Antonioli, Butte; William M. Barelman, Lewistown; Eugene J. P. Drouillard, Missoula; Alfred M. Fulton, Billings; David Gregory, Glasgow; Richard B. Griffing, Great Falls; William E. Harris, Livingston; B. J. Heetderks, Jr., Bozeman; H. D. Huggins, Kalispell; Otto G. Klein, Helena; Everett H. Lindstrom, Helena; D. Stuart MacKenzie, Jr., Havre; George J. Moffitt, Livingston; Richard G. Nollmeyer, Bozeman; Stuart A. Olson, Glendive; Philip D. Pallister, Boulder; Harry W. Power, Great Falls; Stephen N. Preston, Missoula; Warren H. Randall, Miles City; George E. Trobough, Anaconda; William H. Walton, Billings; Robert K. West, Cut Bank.
MATERNAL AND CHILD WELFARE COMMITTEE: Arnold E. Ritt, Chairman, Great Falls.
Subcommittee on Obstetrics: Robert C. Honodel, Chairman, Missoula; Robert E. Asmussen, Great Falls; Joseph H. Brancamp, Butte; J. E. Brann, Kalispell; Robert J. Casey, Great Falls; Thomas R. Clemons, Livingston; Bob E. Hulit, Billings; John C. Seidensticker, Dillon; William H. Sippel, Bozeman; Richard E. Thompson, Glendive; William A. Treat, Miles City.
Subcommittee on Pediatrics: Joseph W. Brinkley, Chairman, Great Falls; L. Bruce Anderson, Billings; Paul R. Ensign, Great Falls; Frank J. Friden, Great Falls; Donald L. Gillespie, Butte; John R. Halseth, Great Falls; Grover Hulla, Missoula; William R. McElwee, Townsend; Orville M. Moore, Helena; Harold C. Schwartz, Missoula; John A. Whittinghill, Billings; David P. Findley, Helena, ex-officio.
MEDIATION COMMITTEE: D. Stuart MacKenzie, Jr., Chairman, Havre, 1961; Gordon A. Anderson, Deer Lodge, 1963; Perry M. Berg, Billings, 1961; Roger W. Clapp, Butte, 1961; Deane C. Epler, Bozeman, 1963; Elmer K. George, Missoula, 1962; John C. Hanley, Great Falls, 1963; Edwin C. Segard, Billings, 1962; William A. Treat, Miles City, 1962.
COMMITTEE ON MENTAL HYGIENE: Bryce G. Hughett, Chairman, Billings; Lawrence A. Campodonico, Miles City; Theodore Chemodurow, Billings; George J. Gelernter, Great Falls; Gladys V. Holmes, Missoula; Walker Honaker, Billings; Edmund P. Jones, Billings; H. Ryle Lewis, Missoula; Philip D. Pallister, Boulder; Hamilton C. Pierce, Great Falls; Robert J. Spratt, Warm Springs; Myron E. Veseth, Havre; Paul H. Visscher, Bozeman; Winfield S. Wilder, Great Falls.
COMMITTEE ON NECROLOGY AND HISTORY OF MEDICINE: Gerald A. Diettert, Chairman, Missoula; Louis W. Allard, Billings; Sidney A. Cooney, Helena; Clyde H. Fredrickson, Kalispell; Harold W. Gregg, Butte; Herbert H. James, Butte; Edward S. Murphy, Missoula; Roy E. Seitz, Bozeman; E. A. Welden, Lewistown; James I. Wernham, Billings; Malcolm D. Winter, Miles City.
NOMINATING COMMITTEE: Herbert T. Caraway, Chairman, Billings; Porter S. Cannon, Conrad; B. C. Farrand, Jordan; Clyde H. Fredrickson, Kalispell; Donald D. Gnose, Missoula.

†Resigned November 1, 1960.
‡Assumed the duties of the President, November 1, 1960, for the unexpired term of Dr. Peterson.

PROGRAM COMMITTEE: Ernst J. Eichwald, Chairman, Great Falls; Eugene J. P. Drouillard, Vice Chairman, Missoula; Hugh V. Anderson, Billings; Robert E. Asmussen, Great Falls; William J. McDonald, Missoula; Donald C. Overy, Great Falls; James W. Quinn, Missoula; Wyman J. Roberts, Great Falls.

PUBLIC HEALTH COMMITTEE: Everett H. Lindstrom, Chairman, Helena; B. C. Farrand, Jordan; N. A. Franken, Havre; John S. Gilson, Great Falls; Walter H. Hagen, Billings; Bryce G. Hughett, Billings; John J. Mitschke, Helena; James E. Murphy, Whitefish; Howard I. Popnoe, Great Falls; S. C. Pratt, Miles City; Arnold E. Ritt, Great Falls; John H. Schaeffer, Billings; Paul J. Seifert, Jr., Libby; George E. Trobough, Anaconda; Mabel E. Tuchscherer, Anaconda.

PUBLIC RELATIONS COMMITTEE: Vernon D. Standish, Chairman, Big Timber; Albert W. Axley, Havre; William B. Danner, Sidney; Herbert H. James, Butte; F. Ervin King, Missoula; George A. Sexton, Great Falls; William H. Sippel, Bozeman; Edwin L. Stickney, Broadus; Walter G. Tanglin, Polson; Scott L. Walker, Anaconda; George D. Waller, Cut Bank; Aubrey H. Wells, Billings.

RHEUMATIC FEVER AND HEART COMMITTEE: John S. Gilson, Chairman, Great Falls; Leonard M. Benjamin, Deer Lodge; Harold A. Braun, Missoula; Deane C. Epler, Bozeman; Frank J. Friden, Great Falls; Donald L. Gillespie, Butte; H. C. Habein, Billings; Donald C. Overy, Great Falls; Harry W. Power, Great Falls; James W. Quinn, Missoula; H. C. Scharnweber, Glasgow; Betty S. Gilson, Great Falls, ex-officio; Mary E. Soules, Helena, ex-officio.

ROCKY MOUNTAIN MEDICAL CONFERENCE COMMITTEE: Deane C. Epler, Chairman, Bozeman, 1961; John R. Burgess, Helena, 1963; Herbert T. Caraway, Billings, 1964; John A. Layne, Great Falls, 1965; Stephen N. Preston, Missoula, 1962; Harold W. Fuller, Great Falls, ex-officio; William E. Harris, Livingston, ex-officio.

RURAL HEALTH COMMITTEE: B. C. Farrand, Chairman, Jordan; Robert J. Hitchens, Chinook; James M. Isbister, Plains; Albert L. Juergens, Dillon; Ronald E. Losee, Ennis; Ernest M. Lovell, Jr., Havre; Donald W. Maclean, Hamilton; Joseph P. Orley, Lewistown; Edwin L. Stickney, Broadus; Warren M. Swager, Jr., Sheridan; Walter G. Tanglin, Polson; Joseph J. Wier, Big Sandy.

TUBERCULOSIS COMMITTEE: John H. Schaeffer, Chairman, Billings; Harry V. Gibson, Great Falls; M. A. Gold, Butte; Arthur C. Knight, Galen; Emmett K. Murphy, Galen; John A. Newman, Butte; Harry W. Power, Great Falls; James W. Quinn, Missoula; Mary E. Soules, Helena, ex-officio.

Special Committees

COMMITTEE ON AGING: James A. Shown, Chairman, Great Falls; A. Kearney Atkinson, Great Falls; George DeBelly, Columbus; Phillip E. Griffin, Billings; Robert G. Kroeze, Butte; R. E. Lemire, Billings; Robert K. West, Cut Bank; M. D. Winter, Jr., Miles City; R. E. Wirth, Missoula.

ARTHRITIS AND RHEUMATISM COMMITTEE: F. Hughes Crago, Chairman, Great Falls; Ralph H. Biehn, Billings; George M. Donich, Anaconda; William G. Ensign, Billings; John F. Fulton, Missoula; William S. Harper, Helena; James L. Patterson, Jr., Butte.

COMMITTEE ON EMERGENCY MEDICAL SERVICE: George E. Trobough, Chairman, Anaconda; Daniel W. Babcock, Missoula; William F. Cashmore, Helena; John S. Gilson, Great Falls; William E. Hadcock, Conrad; William E. Kane, Butte; Jess T. Schwidde, Billings; C. H. Swanson, Jr., Columbus; Robert E. Walker, Livingston; G. D. Carlyle Thompson, Helena, ex-officio.

COMMITTEE ON HIGHWAY SAFETY: William J. McDonald, Chairman, Missoula; Merle D. Fitz, Scobey; Lloyd I. Klatt, Whitehall; Edward C. Maronick, Helena; Robert W. Poundstone, Dillon.

COMMITTEE ON INDIAN HEALTH: Edward L. King, Chairman, Browning; Ward E. Benkelman, Polson; Harry V. Gibson, Great Falls; Arthur C. Knight, Galen; John H. Schaeffer, Billings; George D. Waller, Cut Bank.

ADVISORY COMMITTEE TO INDUSTRIAL ACCIDENT BOARD: James J. McCabe, Chairman, Helena; Perry M. Berg, Billings; John G. Davidson, Butte; John A. Evert, Missoula; Raymond O. Lewis, Helena; Robert F. Muller, Kalispell.

COMMITTEE TO INVESTIGATE MEDICAL SCHOOL EXPANSION: Eugene J. P. Drouillard, Chairman, Missoula; Herbert T. Caraway, Billings; Stuart A. Olson, Glendive; F. L. McPhail, Great Falls, Consultant.

COMMITTEE ON MEDICAL-LEGAL INSTITUTE: Winfield S. Wilder, Chairman, Great Falls; Edward J. Guy, Great Falls; Fred M. Long, Great Falls; Howard I. Popnoe, Great Falls; Thomas C. Power, Great Falls.

COMMITTEE ON SCHOOL HEALTH: Ray O. Bjork, Chairman, Helena; Oscar W. Baltrusch, Billings; F. Hanly Burton, Butte; George M. Donich, Anaconda; Earl L. Hall, Great Falls; Carl W. Hammer, Bozeman; R. W. Hansen, Missoula; Richard H. McLaren, Dillon.

ADVISORY COMMITTEE ON STATE INSTITUTIONS: Philip D. Pallister, Chairman, Boulder; George J. Gelernter, Great Falls; Amos R. Little, Jr., Helena; Paul J. Seifert, Jr., Libby; Robert J. Spratt, Warm Springs.

Nevada State Medical Association

Annual Meeting, August 23-26, 1961

Reno

President: Wesley W. Hall, Reno.
President-elect: James N. Greear, Jr., Reno.
Secretary-Treasurer: William A. O'Brien, III, Reno.
Delegate to A.M.A.: Wesley W. Hall, Reno; alternate: Earl N. Hillstrom, Reno.
Executive Committee: Wesley W. Hall, Reno; James N. Greear, Jr., Reno; Ernest W. Mack, Reno; William A. O'Brien, III, Reno; Earl N. Hillstrom, Reno; John M. Moore, East Ely; John M. Read, Elko; William M. Tappan, Reno; Thomas S. White, Boulder City.
Executive Secretary: Mr. Nelson B. Neff, P. O. Box 2790, Reno; telephone FA. 3-6788.

See March, 1961, issue for complete list of committees.

New Mexico Medical Society*

President: Allan L. Haynes, Clovis.
President-elect: William E. Badger, Hobbs.
Vice President: R. C. Derbyshire, Santa Fe.
Secretary-Treasurer: T. L. Carr, Albuquerque.
Speaker, House of Delegates: C. Pardue Bunch, Artesia.
Vice Speaker, House of Delegates: Omar Legant, Albuquerque.
Councilors: William Hossley, Deming, 1961; Guy E. Rader, Albuquerque, 1961; Robert P. Beaudette, Raton, 1962; William R. Oakes, Los Alamos, 1962; John McCulloch, Farmington, 1963; George Prothro, Clovis, 1963; Gerald Slusser, Artesia, 1963.
Delegate to American Medical Association: Earl L. Malone, Roswell; Alternate: Leland S. Evans, Las Cruces.
Executive Secretary: Mr. Ralph R. Marshall, 220 First National Bank Building, Albuquerque; telephone CH. 2-2102.

The Utah State Medical Association

Annual Session, September 13-15, 1961

Salt Lake City

President: Wallace S. Brooke, Salt Lake City.
President-elect: Ralph E. Jorgenson, Provo.
Secretary: John F. Waldo, Salt Lake City, 1963.
Treasurer: Edward R. McKay, Salt Lake City, 1963.
Councilors: Box Elder, D. L. Bunderson, Brigham City, 1960; Cache Valley, C. J. Daines, Logan, 1960; Carbon County, A. R. Demman, Helper, 1961; Central Utah, LaMar H. Stewart, Gunnison, 1962; Salt Lake County, R. W. Sonntag, Salt Lake City, 1960; Southern Utah, L. V. Broadbent, Cedar City, 1963; Uintah Basin, Vernon C. Young, Vernal, 1961; Utah County, Richard A. Call, Provo, 1963; Weber County, Wendell J. Thomson, Ogden, 1961.
Executive Committee: Wallace S. Brooke, Salt Lake City; I. Bruce McQuarrie, Ogden; Ralph E. Jorgenson, Provo; John F. Waldo, Salt Lake City; Edward R. McKay, Salt Lake City.
Delegate to American Medical Association: Drew M. Petersen, Ogden; Alternate: Stanley R. Child, Salt Lake City.
Executive Secretary: Mr. Harold Bowman, 42 South Fifth East Street, Salt Lake City 2; telephone EL. 5-7477.

See November, 1960, issue for complete list of committees.

Wyoming State Medical Society

Annual Session, September 18-21, 1961

Jackson Lake Lodge

OFFICERS—1960-1961—Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1961 Annual Session.

President: Francis A. Barrett, Cheyenne.
President-elect: F. H. Haigler, Casper.
Vice President: S. J. Giovale, Cheyenne.
Secretary: John H. Froyd, Worland.
Treasurer: C. D. Anton, Cheyenne.
Delegate to A.M.A.: B. J. Sullivan, Laramie.
Alternate Delegate to A.M.A.: R. W. Holmes, Casper.

*Committee lists for all participating states will appear in subsequent issues.

Executive Secretary: Mr. Arthur R. Abbey, Cheyenne.
Councilors: Albany County, Eugene C. Pelton, Laramie, 1962; Carbon County, James E. Cashman, Rawlins, 1963; Converse County, E. George Johnson, Douglas, 1963; Fremont County, Paul Holtz, Lander, 1963; Goshen County, O. C. Reed, Torrington, 1962; Johnson County, Thomas A. Nicholas, Buffalo, 1963; Laramie County, David M. Flett, Cheyenne, 1962; Natrona County, Roy Holmes, Casper, 1962; Northeastern Wyoming, Virgil Thorpe, Newcastle, 1961; Northwest Wyoming, Ray K. Christensen, Powell, 1963; Sheridan County, Ralph Arnold, Sheridan, 1962; Sweetwater County, Howard P. Greaves, Rock Springs, 1961; Teton County, D. G. MacLeod, Jackson, 1961; Uinta County, J. S. Hellewell, Evanston, 1961.

Elected committees

ADVISORY COMMITTEE TO SELECTIVE SERVICE ON PROCUREMENT AND ASSIGNMENT OF PHYSICIANS: Sam S. Zuckerman, Chairman, Cheyenne, 1961; Paul Yedinak, Rock Springs, 1962; James Cashman, Rawlins, 1963.
BLUE CROSS TRUSTEES: F. H. Haigler, Casper, 1962; Eugene C. Pelton, Laramie, 1961.
BLUE SHIELD TRUSTEES: Nels A. Vicklund, Thermopolis, 1961; Mr. Rudolph Anselmi, Rock Springs, 1961; Bernard D. Stack, Riverton, 1961; Francis A. Barrett, Cheyenne, 1961; Mr. Roy Chamberlain, Lusk, 1962; Mr. Norman T. Barlow, Cora, 1962; John A. Knebel, Buffalo, 1962; Bernard J. Sullivan, Laramie, 1962; E. George Johnson, Douglas, 1963; Ralph J. Malott, Casper, 1963; Mr. Ewing T. Kerr, Cheyenne, 1963; D. G. MacLeod, Jackson, 1963.
FEE SCHEDULE COMMITTEE: G. L. Smith, Chairman, Cheyenne, 1961; Ralph J. Malott, Secretary, Casper, 1961.
GRIEVANCE COMMITTEE (Appointed by the President with Approval of the Council): Benjamin Gitlitz, Thermopolis, 1962; Pete M. Schunk, Sheridan, 1961; H. B. Anderson, Casper, 1962; Charles R. Lowe, Casper, 1963.
ROCKY MOUNTAIN MEDICAL CONFERENCE: Frederick H. Haigler, Chairman, Casper, 1961; Paul R. Yedinak, Rock Springs, 1961; J. S. Hellewell, Evanston, 1962; James W. Barber, Cheyenne, 1963; Virgil L. Thorpe, Newcastle, 1963.

Appointed committees

AMERICAN MEDICAL EDUCATION FOUNDATION: Wilbur Hart, Chairman, Casper, 1963; William A. Hinrichs, Douglas, 1961; Raymond E. Kunkel, Thermopolis, 1961; John H. Waters, Evanston, 1961; E. W. Richards, Riverton, 1961; John H. Froyd, Worland, 1961; D. G. MacLeod, Jackson, 1961; Paul R. Yedinak, Rock Springs, 1961; Richard C. Baughman, Gillette, 1961; Henry N. Stephenson, Newcastle, 1961; O. E. Torkelson, Lusk, 1961; Kayo Smith, Torrington, 1961; Curtis L. Rogers, Sheridan, 1962; Paul R. Holtz, Lander, 1962; Orson L. Treloar, Afton, 1962; Jesse Simons, Cheyenne, 1962; Paul A. Kos, Rock Springs, 1962; Guy M. Halsey, Rawlins, 1962; John R. Bunch, Laramie, 1963; Chester E. Ridgway, Cody, 1963; William E. Rosene, Wheatland, 1963.
CANCER COMMITTEE: John A. Knebel, Chairman, Buffalo, 1962; Dan B. Greer, Cheyenne, 1962; Willis M. Franz, Newcastle, 1961; John B. Gramlich, Cheyenne, 1961; Cecil R. Reinstein, Cheyenne, 1961; R. H. Bowden, Casper, 1963; Edward E. Gallaghan, Riverton, 1963.
CARDIOVASCULAR AND RENAL DISEASES AND PROBLEMS OF AGING: Charles R. Lowe, Chairman, Casper, 1963; Joseph E. Clark, Casper, 1961; L. D. Kattenhorn, Powell, 1961; Norman R. Black, Cheyenne, 1962; Joseph R. Volk, Jr., Torrington, 1962; Thomas Nicholas, Buffalo, 1963.
CHILD HEALTH COMMITTEE: R. E. Kunkel, Chairman, Thermopolis, 1962; Lawrence J. Cohen, Cheyenne, 1961; Carleton D. Anton, Cheyenne, 1962; Oliver K. Scott, Casper, 1963.
CONSTITUTION AND BY-LAWS COMMITTEE: Joseph P. Murphy, Chairman, Casper, 1963; Eugene C. Pelton, Laramie, 1961; Curtis L. Rogers, Sheridan, 1962; H. B. Anderson, Casper, 1963.
COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE AND CIVIL DEFENSE: George Phelphs, Regional Coordinator, Cheyenne, 1961; E. L. Lindahl, Co-chairman, Lusk, 1963; Lundie Barlow, Co-chairman, Cheyenne, 1963; Paul Preston, Cheyenne, 1961; Frederick H. Haigler, Casper, 1961; R. E. Kunkel, Thermopolis, 1962; B. D. Stack, Riverton, 1962; Richard C. Stratton, Green River, 1962; Charles G. Vivion, Jr., Laramie, 1963; Louis Booth, Sheridan, 1963; Cecil Reinstein, Cheyenne, 1963.
CREDENTIALS COMMITTEE: John H. Froyd, Chairman, Worland, 1961; C. D. Anton, Treasurer, Cheyenne, 1961; S. J. Giovale, Vice President, Cheyenne, 1961.
GOTTSCHE FOUNDATION ADVISORY COMMITTEE: James W. Sampson, Chairman, Cheyenne, 1962; Robert M. Fowler, Casper, 1961; Benjamin Gitlitz, Thermopolis, 1963; G. Myron Harrison, Rock Springs, 1962; Paul J. Preston, Cheyenne, 1963; J. Cedric Jones, Cody, 1961.
JUDICIAL AND ADVISORY COMMITTEE TO WORKMEN'S COMPENSATION DEPARTMENT: District No. 7, George M. Knapp, Chairman, Casper, 1961; District No. 1, Leon H. Schreiner, Cheyenne, 1961; District No. 1, Paul J. Preston, Cheyenne, 1962; District No. 1, James A. Cashman, Rawlins, 1962; District No. 2, G. Myron Harrison, Rock Springs, 1963; District No. 3, Jack B. Bennett, Evanston, 1963; District No. 4, James W. Sampson, Cheyenne, 1961; District No. 5, Richard J. Giever, Powell, 1963; District No. 6, Oliver E. Torkelson, Lusk, 1962.
MATERNAL WELFARE: William Thaler, Chairman, Casper, 1963; R. Dale Ashbaugh, Riverton, 1961; Robert M. Fowler, Casper, 1961; Carleton D. Anton, Cheyenne, 1962; Oscar Rojo, Sheridan, 1962; Bane Travis, Cheyenne, 1963.
MEDICAL ECONOMICS: E. Chester Ridgway, Chairman, Cody, 1963; John B. Krahl, Torrington, 1961; J. B. Bennett, Evanston, 1961; Willard H. Pennoyer, Cheyenne, 1962; James W. Barber, Cheyenne, 1962; Jack R. Rhodes, Sheridan, 1963; DeWitt Dominick, Cody, 1963; John Froyd, Worland, 1963.
MENTAL HEALTH: Don W. Herrold, Chairman, Cheyenne, 1961; Seymour Thickman, Sheridan, 1962; William N. Karn, Jr., Evanston, 1962; Mark P. Farrell, Jr., Casper, 1963; Jesse Simons, Cheyenne, 1963.
NECROLOGY: James W. Sampson, Chairman, Cheyenne, 1962.
NOMINATING: Frederick H. Haigler, President-elect, Chairman, Casper, 1961; Francis A. Barrett, President, Cheyenne, 1961; John H. Froyd, Secretary, Worland, 1961; C. D. Anton, Treasurer, Cheyenne, 1961; Chairman of the Delegation from Johnson County; Chairman of the Delegation from Fremont County; Chairman of the Delegation from Goshen County; Chairman of the Delegation from Albany County; all Past Presidents, Past Secretaries and Past Treasurers.
ORGANIZATION STUDY AND RESEARCH: H. B. Anderson, Chairman, Casper, 1961; Roy W. Holmes, Casper, 1961; Joseph P. Murphy, Casper, 1961; Frederick H. Haigler, Casper, 1961.
ORIENTATION PROGRAM: S. J. Giovale, Vice President, Chairman, Cheyenne, 1963; J. Cedric Jones, Cody, 1961; F. H. Haigler, Casper, 1962; James W. Sampson, Cheyenne, 1962; Benjamin Gitlitz, Thermopolis, 1963.
PARLIAMENTARIAN: John H. Froyd, Worland, 1961.
PROGRAM: Francis A. Barrett, President, Chairman, Cheyenne, 1961; F. H. Haigler, President-elect, Casper, 1961; S. J. Giovale, Vice President, Cheyenne, 1961; John H. Froyd, Secretary, Worland, 1961; Paul J. Preston, Cheyenne, 1961; Leon H. Schreiner, Cheyenne, 1961; Walter R. Cockley, Cheyenne, 1961; Benjamin Gitlitz, Thermopolis, 1961.
PUBLIC POLICY AND LEGISLATION: James W. Barber, Chairman, Cheyenne, 1963; Williard H. Pennoyer, Cheyenne, 1961; Harlan B. Anderson, Casper, 1961; Albert T. Sudman, Green River, 1961; W. Andrew Bunten, Cheyenne, 1962; N. E. Morad, Casper, 1962; Brendan P. Phibbs, Casper, 1962; Norman R. Black, Cheyenne, 1963; Laurence W. Greene, Jr., Laramie, 1963.
PUBLIC RELATIONS: S. J. Giovale, Chairman, Cheyenne, 1962; Curtis L. Rogers, Sheridan, 1961; Benjamin Gitlitz, Thermopolis, 1963; and all 1960 County Medical Society Presidents.
ADVISORY COMMITTEE ON RADIATION PROBLEMS: James W. Barber, Chairman, Cheyenne, 1962.
RESOLUTIONS: Frederick H. Haigler, President-elect, Chairman, Casper, 1961; S. J. Giovale, Vice President, Cheyenne, 1961; Chairman of the Delegation from Sheridan County; Chairman of the Delegation from Natrona County; Chairman of the Delegation from Northeast Wyoming; Chairman of the Delegation from Carbon County.
ROCKY MOUNTAIN MEDICAL CONFERENCE: Frederick H. Haigler, Chairman, Casper, 1961; Paul R. Yedinak, Rock Springs, 1961; J. S. Hellewell, Evanston, 1962; James W. Barber, Cheyenne, 1963; Virgil L. Thorpe, Newcastle, 1963.
RURAL HEALTH: C. R. Reinstein, Chairman, Cheyenne, 1963; Henry N. Stephenson, Newcastle, 1961; Charles Roland, Jr., Rawlins, 1961; Lawrence F. McCarty, Laramie, 1962; John H. Froyd, Worland, 1962; D. A. Holt, Evanston, 1963.
STATE INSTITUTIONS ADVISORY COMMITTEE: William N. Karn, Jr., Chairman, Evanston, 1962; John H. Froyd, Worland, 1961; James W. Sampson, Cheyenne, 1961; Russell H. Kanable, Basin, 1962; L. Harmon Wilmoth, Lander, 1962; James E. Cashman, Rawlins, 1963; Raymond E. Kunkel, Thermopolis, 1963.
ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY: Joseph E. Hoadley, Chairman, Gillette, 1961; Joseph Clark, Casper, 1962; Ralph Arnold, Sheridan, 1963.
COMMITTEE ON WYOMING TUBERCULOSIS PROBLEMS: Roy W. Holmes, Chairman, Casper, 1961; Russell H. Kanable, Basin, 1961; S. J. Giovale, Cheyenne, 1962; Max Smith, Rawlins, 1963; Walter T. Snow, Rock Springs, 1963; K. R. Petsch, Cheyenne, 1963.

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WANTED: Board Eligible Surgeon or Board Surgeon for association with small group in central Wyoming. If interested, please write to Box 5-8-2, Rocky Mountain Medical Journal, 835 Republic Bldg., Denver, Colorado. 5-8-2

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GP with some surgical ability wanted NOW; Whitefish Clinic, Whitefish, Mont.; telephone UN. 2-1501, or UN. 2-1293 (home); skiing, hunting and fishing. 4-1-TF

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TWO GP's for summer work in a natl. park. One must be available from June 15 to Sept. 15 and one must be available from July 1 to August 30. Write Box 4-3-TF, Rocky Mountain Medical Journal, 835 Republic Bldg., Denver, Colo. 4-3-TF

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